

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2914

CERTIFICATE OF DEATH

02896

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Sykesville				c. LENGTH OF STAY IN 1b 6mo. 19d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH (SALLY) Middle ANN Last AMENT				4. DATE OF DEATH Month March Day 18 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1870	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Winfield Morgan				14. MOTHER'S MAIDEN NAME Jane E. Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.							
INTERVAL BETWEEN ONSET AND DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 29, 1960 to March 18, 1961 , that (I) (we) last saw the deceased alive on March 18, 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Heinz H. Klaatsch, M.D.				22b. DATE SIGNED 3-18-61			
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 21, 1961			
23c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hamden)				23d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee				25a. REC'D BY REGISTRAR MAR 20 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2915

02897

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown				c. LENGTH OF STAY IN 1b X Rural Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Osborn Last Armiger				4. DATE OF DEATH Month March Day 6 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1883	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission merchant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James S. Armiger				14. MOTHER'S MAIDEN NAME Sarah Calvert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Lelia G. Baldwin R #1, Taneytown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Throat (Primary site undetermined) 148 X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Arteriosclerotic Heart Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 19 58 to 3/6 19 60 that (I) (we) last saw the deceased alive on 4/25 19 60 and that death occurred at 12 N from the causes and on the date stated above.							
22a. SIGNATURE R. S. McVaugh				22b. DATE SIGNED 3/6/61			
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh				22d. ADDRESS Taneytown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF March 9, 1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City, town, or county) (State) 3801 Fred. Rd., Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Hiles E. O. Fuss & Son				25a. REC'D BY REGISTRAR MAR 9 '61			
ADDRESS Taneytown, Maryland				25b. REGISTRAR'S SIGNATURE Arthur L. Hoad			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the funeral director, or by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2916
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02898

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13 X-2	
f. STREET ADDRESS Sunset Drive, RFD#1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earl Middle Barnes Last Barnes		4. DATE OF DEATH Month March Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1918
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR: Months 43 Days 43 Hours 43 Min. 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship fitter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Barnes		14. MOTHER'S MAIDEN NAME Susie Schaeffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-9362	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis DUE TO (b) Perforated ulcerative colitis DUE TO (c) Bronchopneumonia, bilateral CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with conv. disorder with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Day Week Days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1961 to March 23, 1961 , that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred at 3:00 AM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE 3/23/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-61	
23c. NAME OF CEMETERY OR CREMATORY Asbury Methodist		23d. LOCATION (City, town, or county) (State) Arnold, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C.Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR DATE MAR 27 '61	
25b. REGISTRAR'S SIGNATURE Christina L. Hines			

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VR A15 (4)
15M 9/59

1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2917

CERTIFICATE OF DEATH

02899

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12yrs. 2mos. 17 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 106 S. Fagley Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah or Serafina First Capilli Middle Bonanno Last		4. DATE OF DEATH Month March Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 66 Days 28 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Petro Capilli		14. MOTHER'S MAIDEN NAME Frances Ordilli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-9628	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 465 X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Involuntional psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1956 to March 28, 1961 , that (I) (we) last saw the deceased alive on March 28, 1961 , and that death occurred at 8:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 3/29/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1st/61	
23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM.		23d. LOCATION (City, town, or county) (State) BALTIMORE MD	
24. GENERAL DIRECTOR'S SIGNATURE Frank Bellahose		25a. REC'D BY REGISTRAR APR 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. ADDRESS 322 S. High St.	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the attending physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2918
CERTIFICATE OF DEATH
02900

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos. 7 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Lucille Last Bowman		4. DATE OF DEATH Month March Day 5 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-22
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR: Months 38 Days 38 Hours 38 Min. 38	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence St. Clair		14. MOTHER'S MAIDEN NAME Charlotte Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-18-7560	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia probably due to aspiration 491X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 19 60 to March 5, 19 61 that (I) (we) last saw the deceased alive on March 5, 19 61 , and that death occurred at 7:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED March 5, 1961	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/61	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph W. Martin		25a. REC'D BY REGISTRAR MAR 8 '61	
ADDRESS Rest Haven Funeral Chapel Hagerstown		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2919 **CERTIFICATE OF DEATH**

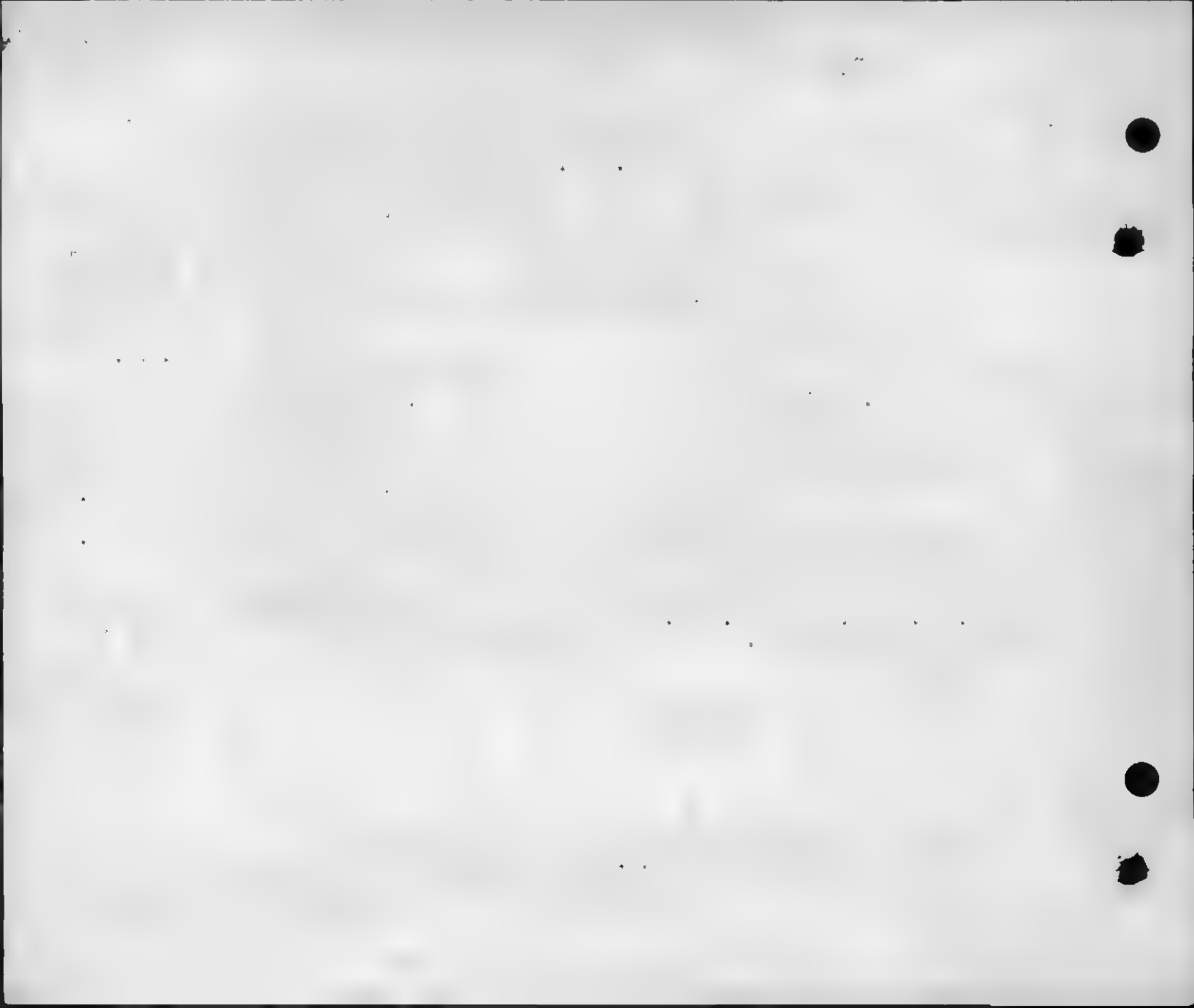
02901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ibex Nursing Home Westminster, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Herbert Augustus Buckingham</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3, 1879</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Nelson Buckingham</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Garrettson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-09-8166</u>		INFORMANT Address <u>Ibex Nursing Home Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of bowel</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1960</u> to <u>1961</u> that I last saw the deceased alive on <u>Feb. 28, 1961</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Reesewilkins, 151 Center ave Westminster, Md.</u> DATE SIGNED <u>3/3/61</u>							
ACTUAL SIGNATURE <u>E. REESE WILKINS</u>		PHYSICIAN'S NAME (Type) <u>E. REESE WILKINS Westminster, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Saffell</u>				ADDRESS <u>254 E Main St. Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by a physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

(M)

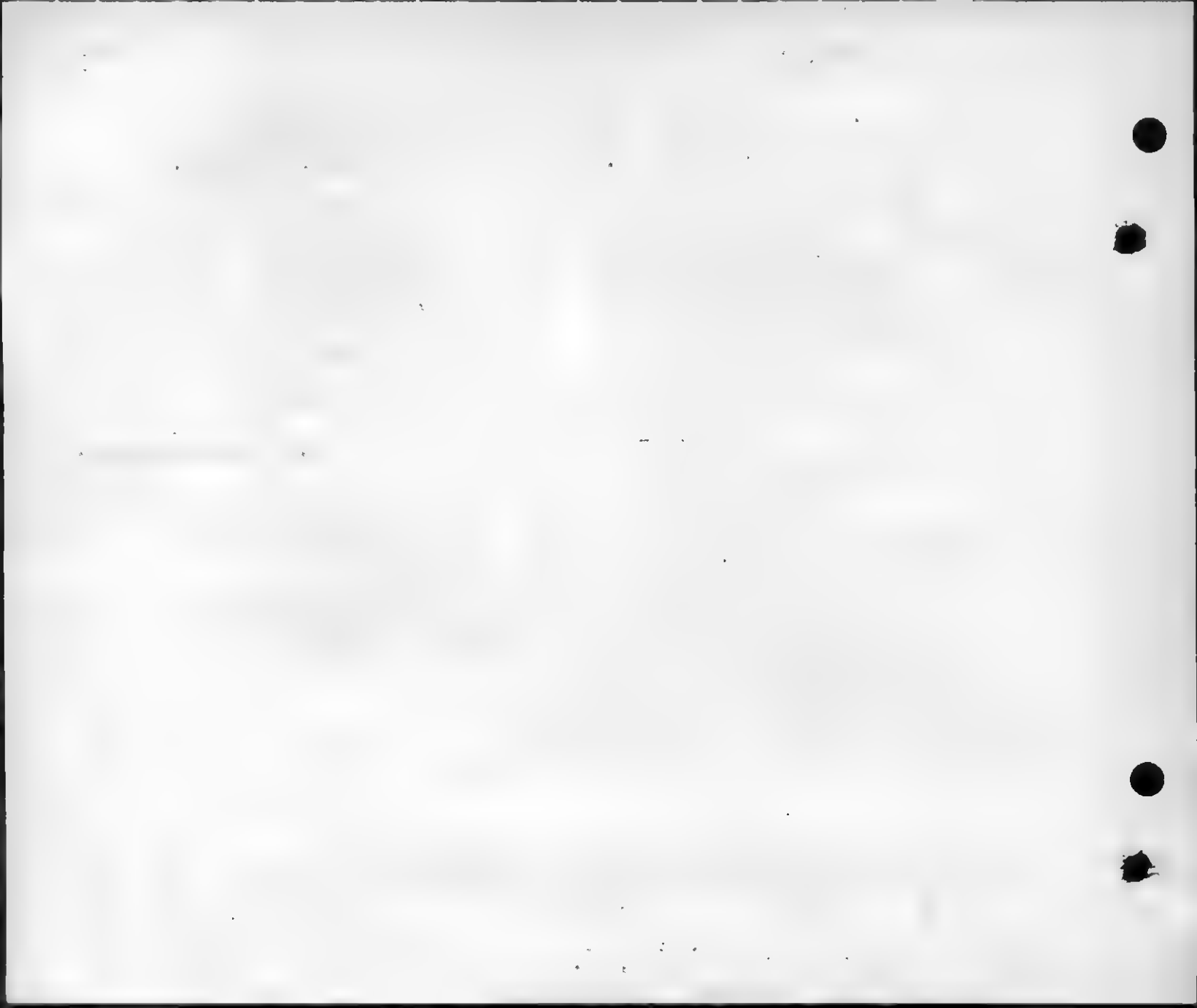
W H FOARD

1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2921

02903

1 PLACE OF DEATH a. COUNTY Carroll Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster, Md. c. LENGTH OF STAY IN 1b 13 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Manchester Road		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster, Md. Rd. #4 d. STREET ADDRESS Manchester Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Agatha Conant		4. DATE OF DEATH Month Day Year March 4 19 61	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1871
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months Days Hours Min March 4 19 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY garment	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Gaines		14. MOTHER'S MAIDEN NAME Mary G. LaMoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ** **		16. SOCIAL SECURITY NO 008-16-9925	
17. INFORMANT son Ralph Conant		Address Manchester Rd. Rd. #4 Westminster, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Generalized Arteriosclerosis DUE TO (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Mar 21 1960 to March 4 1961 , that (I) (we) last saw the deceased alive on March 4 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W H Foard		22b. DATE SIGNED March 4 1961	
22c. PHYSICIAN'S NAME (Type) W H Foard M.D.		22d. ADDRESS Manchester, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/7/61	23c. NAME OF CEMETERY OR CREMATORY Child's Cemetery	23d. LOCATION (City, town, or county) (State) Cornish Flat New Hampshire
24. FUNERAL DIRECTOR'S SIGNATURE James J. Lafferty		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
ADDRESS 254 E. Main St. Westminster, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

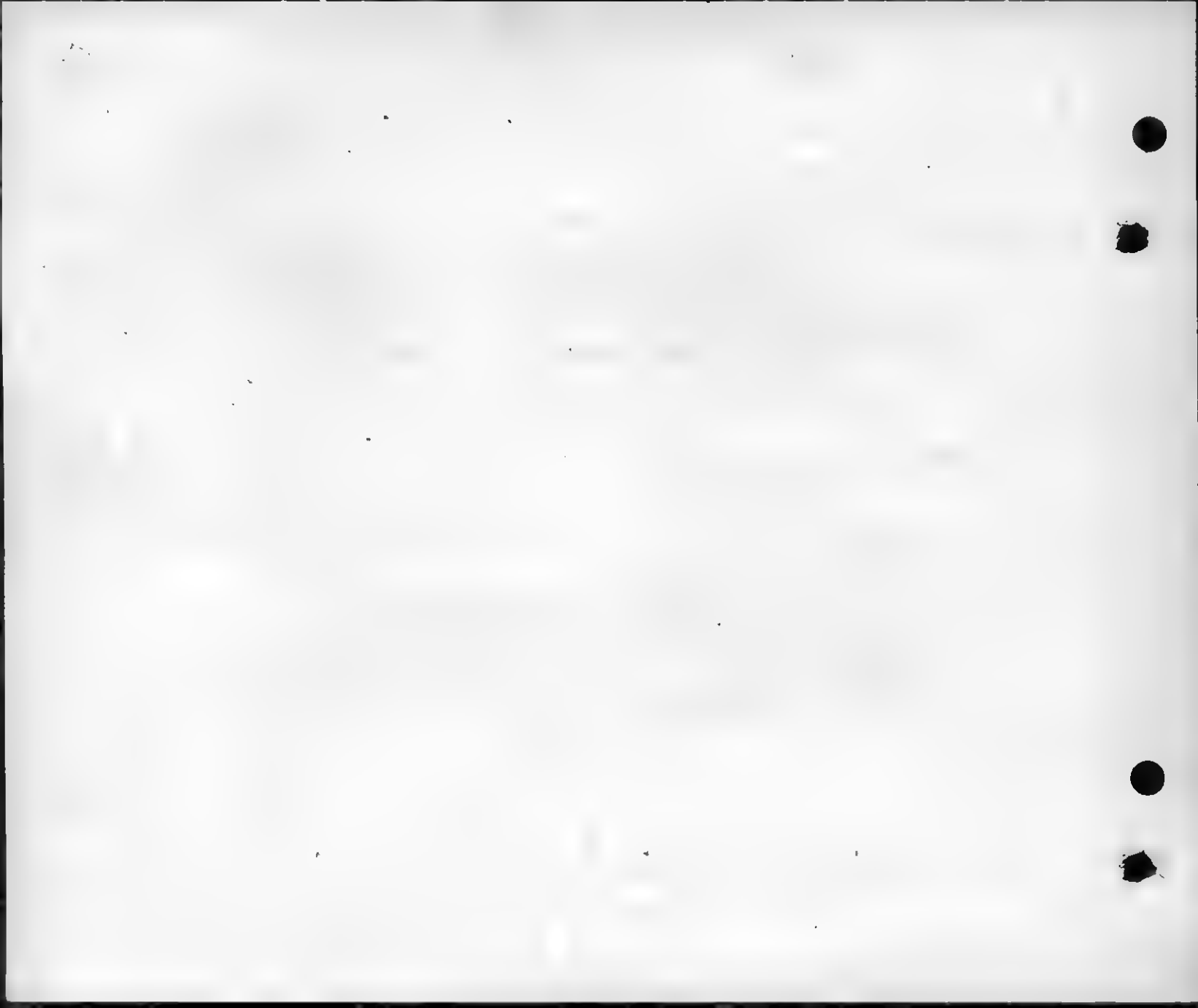


Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by a hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2922 CERTIFICATE OF DEATH 02904

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OLIVER - W - COX</u>				4. DATE OF DEATH Month Day Year <u>March 10 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10 - 1951</u>	9. AGE (In years last birthday) <u>79</u> yrs	F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hammer</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Oliver W Cox</u>				14. MOTHER'S MAIDEN NAME <u>Susan Wilhelms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>720</u>			
				17. INFORMANT Address <u>Mrs Oliver Cox - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Carcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Arterio Sclerotic C & V disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 1959</u> to <u>March 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> 19 <u>61</u> , and that death occurred at <u>7</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>M. C. Porterfield</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>				22d. ADDRESS <u>Hampstead, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Foreston Maus.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin C. Tipton</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

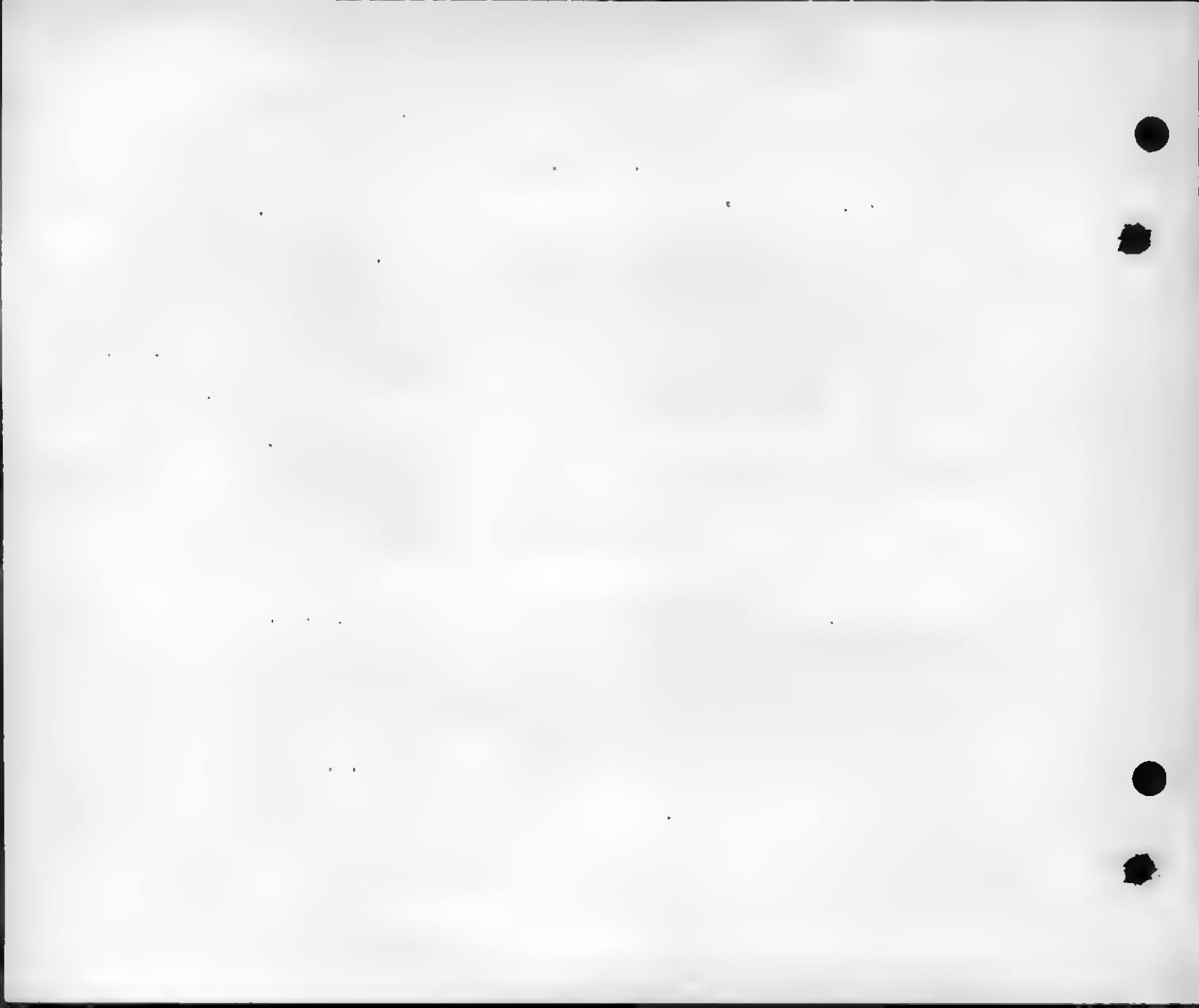


2923
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
Items 23a, c & d Film 6203 3/20/61 1wk

02905

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4 yrs./5 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore #2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #2 d. STREET ADDRESS 924 N. Calvert St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry CRONHARDT, Jr.		4. DATE OF DEATH Month Day Year 3 11 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/76
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Cronhardt		14. MOTHER'S MAIDEN NAME Louise Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia right lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile brain disease with psychotic reaction. CBS assoc. with disturbance of metabolism, growth or nutrition, with			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/4/56 to 3/11/61 , 19____, that (I) (we) last saw the deceased alive on 3/11/61 , 19____, and that death occurred at 8:30 a.m. from the causes and on the date stated above			
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE 3/11/61 22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-61	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Marshall		25a. REC'D BY REGISTRAR MAR 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

I



Reg. Dist. No. 02906

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		4. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookfield Manor</u>		c. LENGTH OF STAY IN Ib <u>11 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookfield Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH BENJAMIN DARR</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bertram J. Carr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Hayes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>212-01-8761</u>	
17. INFORMANT <u>Generalized Arteriosclerosis</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1961</u>	
21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Old left hemiparesis Multiple sacral deubility ulcers</u>		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1185 Main, Union Bridge Md</u>	
23. (City or town) <u>Union Bridge</u>		(County) <u>Carroll</u>	
(State) <u>Md</u>		24. I certify that I attended the deceased from <u>1/23/61</u> 19 <u>61</u> , to <u>3/16/61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>3/12/61</u> 19 <u>61</u> , and that death occurred at <u>2 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>J. H. Caricote</u>		DATE SIGNED <u>3/16/61</u>	
PHYSICIAN'S NAME (Type) <u>J. H. CARICOTE</u>		25. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
26. DATE THEREOF <u>3/18/61</u>		27. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster, Md.</u>	
28. LOCATION (City, town, or county) <u>Westminster, Md.</u>		(State) <u>Md.</u>	
29. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Higgins & Son, Westminster, Md.</u>		30. REC'D BY REGISTRAR <u>Arthur S. Kiana</u>	
31. ADDRESS <u>1185 Main, Union Bridge Md</u>		32. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2925

02907

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State H ospital				d. STREET ADDRESS 920 E. C Street			
3. NAME OF DECEASED (Type or print) First Gertrude Middle May Last Decker				4. DATE OF DEATH Month March Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-77	
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S..A							
13. FATHER'S NAME James Mitchell				14. MOTHER'S MAIDEN NAME Ellen Lowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 6-		17. INFORMANT Springfield Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease with psychotic reaction				INTERVAL BETWEEN ONSET AND DEATH da ys			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1-23- 1961 to 3-14- 1961 , that (I) (we) last saw the deceased alive on 3-14- 1961 , and that death occurred at 7:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 14, 1961	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/17/61		23c. NAME OF CEMETERY OR CREMATORY Park Heights	
23d. LOCATION (City, town, or county) (State) Brunswick Md							
24. FUNERAL DIRECTOR'S SIGNATURE B. J. ...				ADDRESS Brunswick, Md		25a. REC'D BY REGISTRAR MAR 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

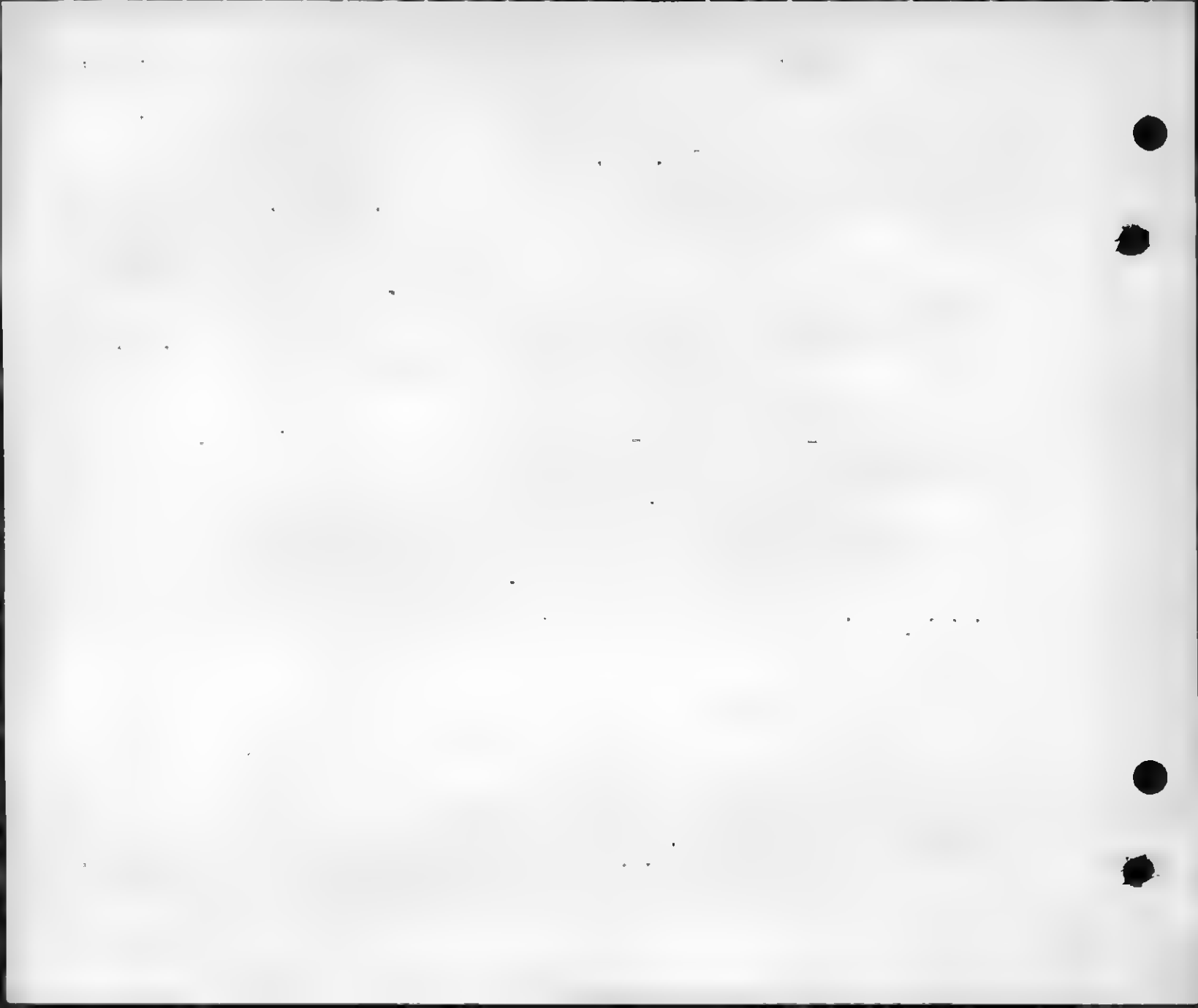
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ISM 9/59

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2926

02908

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr.7mos.15days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18 d. STREET ADDRESS 2010 St. Paul St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophia Middle Meta Last Dohrman		4. DATE OF DEATH Month March Day 29 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY Franklin-Uniform Co Maryland Balto.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ulrich Bruberger		14. MOTHER'S MAIDEN NAME Fredricka Grages	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-09-2786	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Arteriosclerotic heart disease PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase. (Aphasic)			
INTERVAL BETWEEN ONSET AND DEATH days days years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 14, 1959 to March 29, 1961 , that (I) (we) last saw the deceased alive on March 29, 1961 , and that death occurred at 10:30AM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE 3/29/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/61	
23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		25a. REC'D BY REGISTRAR APR 3 1961	
ADDRESS 3331 Brehms Lane		25b. REGISTRAR'S SIGNATURE Charles E. Schimunek	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

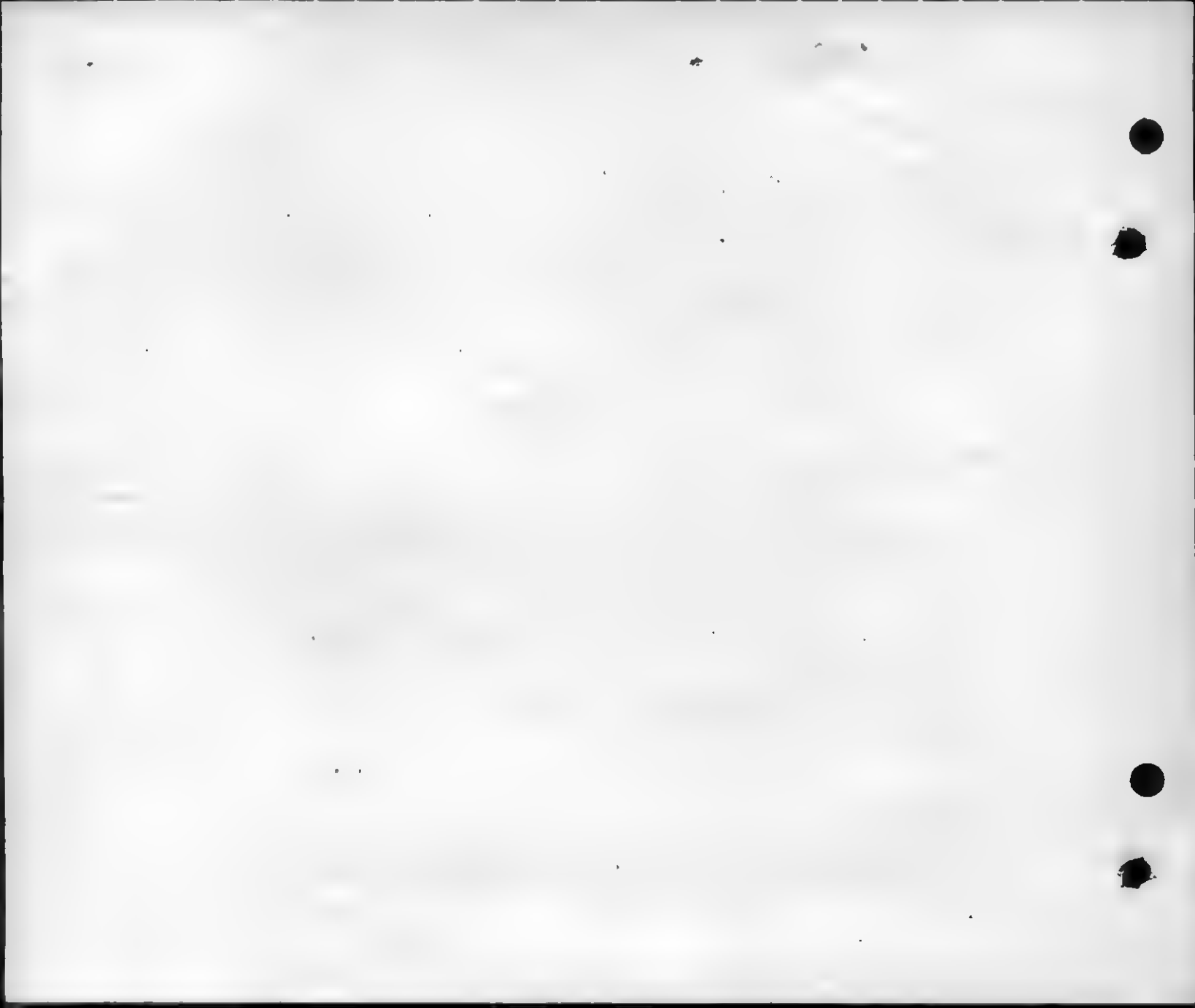
CERTIFICATE OF DEATH

2927

Item 9 rlm-262 3-14-61 et

02909

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm'ssion) a. STATE Maryland b. COUNTY Baltimore #5	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1601 E. Madison St.	
3. NAME OF DECEASED (Type or print) PAWELON Paul First EWCHUK Middle EWCHUK Last		4. DATE OF DEATH Month 3 Day 4 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-83
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ship cleaner		10b. KIND OF BUSINESS OR INDUSTRY WATER FRONT	
11. BIRTHPLACE (State or foreign country) Ukrania		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-09-0189 4	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) failure Arteriosclerotic heart disease with congestive 420.0 DUE TO (b) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITION ON <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/27/60 to 3/4/61 , 19____ that (I) (we) last saw the deceased alive on 3/4/61 , 19____, and that death occurred at 6:30 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 3/4/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR 7 1961	
23c. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEM		23d. LOCATION (City, town, or county) (State) ELLERIDGE MD	
24. FUNERAL DIRECTOR'S SIGNATURE Ruppel Bros ADDRESS 1800 E LOYBARO ST		25a. REC'D BY REGISTRAR MAR 7 '61 DATE	
		25b. REG STRAR'S SIGNATURE Arthur L. Harris	

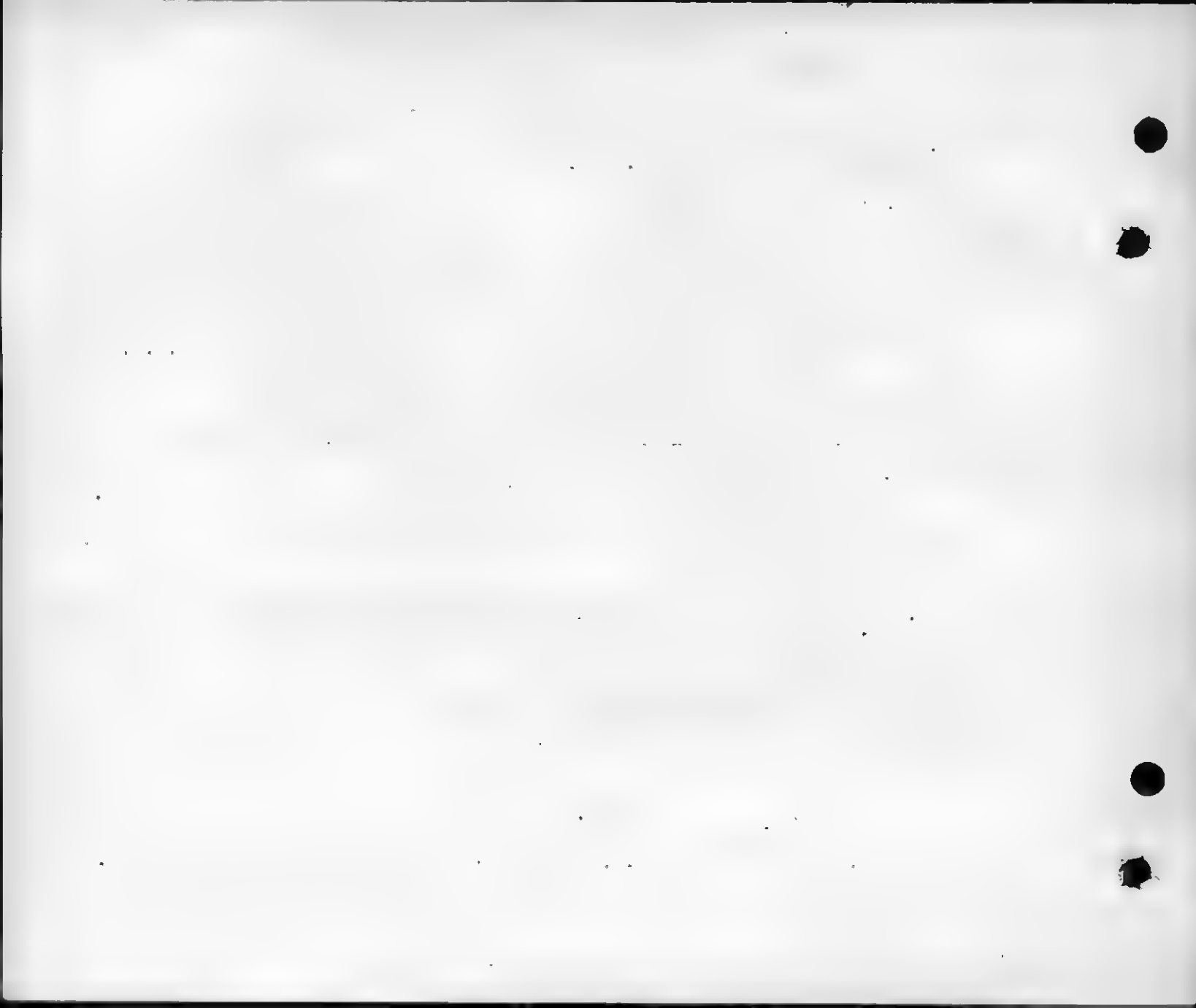


Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be signed by a funeral director or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2928
CERTIFICATE OF DEATH

02910

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9mos.16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. STREET ADDRESS 2926 Harford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Young Last Folkemer		4. DATE OF DEATH Month March Day 3 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Young		14. MOTHER'S MAIDEN NAME Margaret Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-03-2707-A	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 17, 1960 to March 3, 1961 that (I) (we) last saw the deceased alive on March 2, 1961 and that death occurred at 1:30AM from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 3/3/61	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/1961	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Parkville Baltimore MD	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Smith		25a. REC'D BY REGISTRAR DATE 6 '61	
ADDRESS 3209 Oak Rd Baltimore Md		25b. REGISTRAR'S SIGNATURE S. T. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2929

02911

1. PLACE OF DEATH a. COUNTY <u>Chesapeake</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Chesapeake</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster (Md) Hollys</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Chandler St</u>				d. STREET ADDRESS <u>26 Chandler St</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FRANCES</u> Last <u>FRISBY</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8 1893</u>	9. AGE (In years lost birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Frisby</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>3</u>		17. INFORMANT <u>J. A. Frisby, Westminster Md</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension & Valvular Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>61</u> to <u>3/7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>61</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Julius Chapko</u>				22b. DATE SIGNED <u>3/16</u>		22c. PHYSICIAN'S NAME (Type) <u>Julius Chapko</u>	
22d. ADDRESS <u>854 W. Green St Westminster Md</u>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer</u>				ADDRESS <u>Westminster Md</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>MAR 14 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

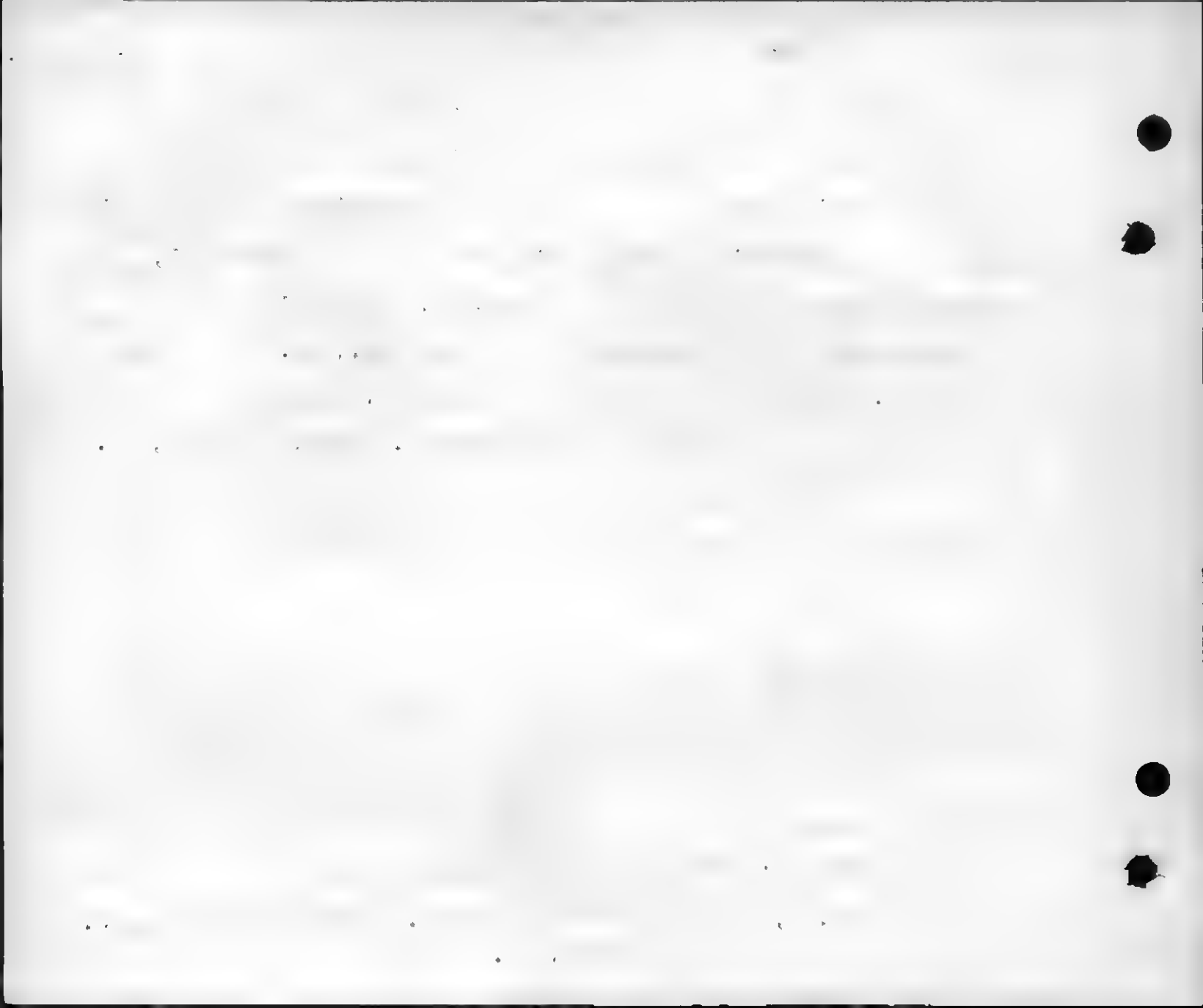
2930

CERTIFICATE OF DEATH

Reg. Dist. No. 02913

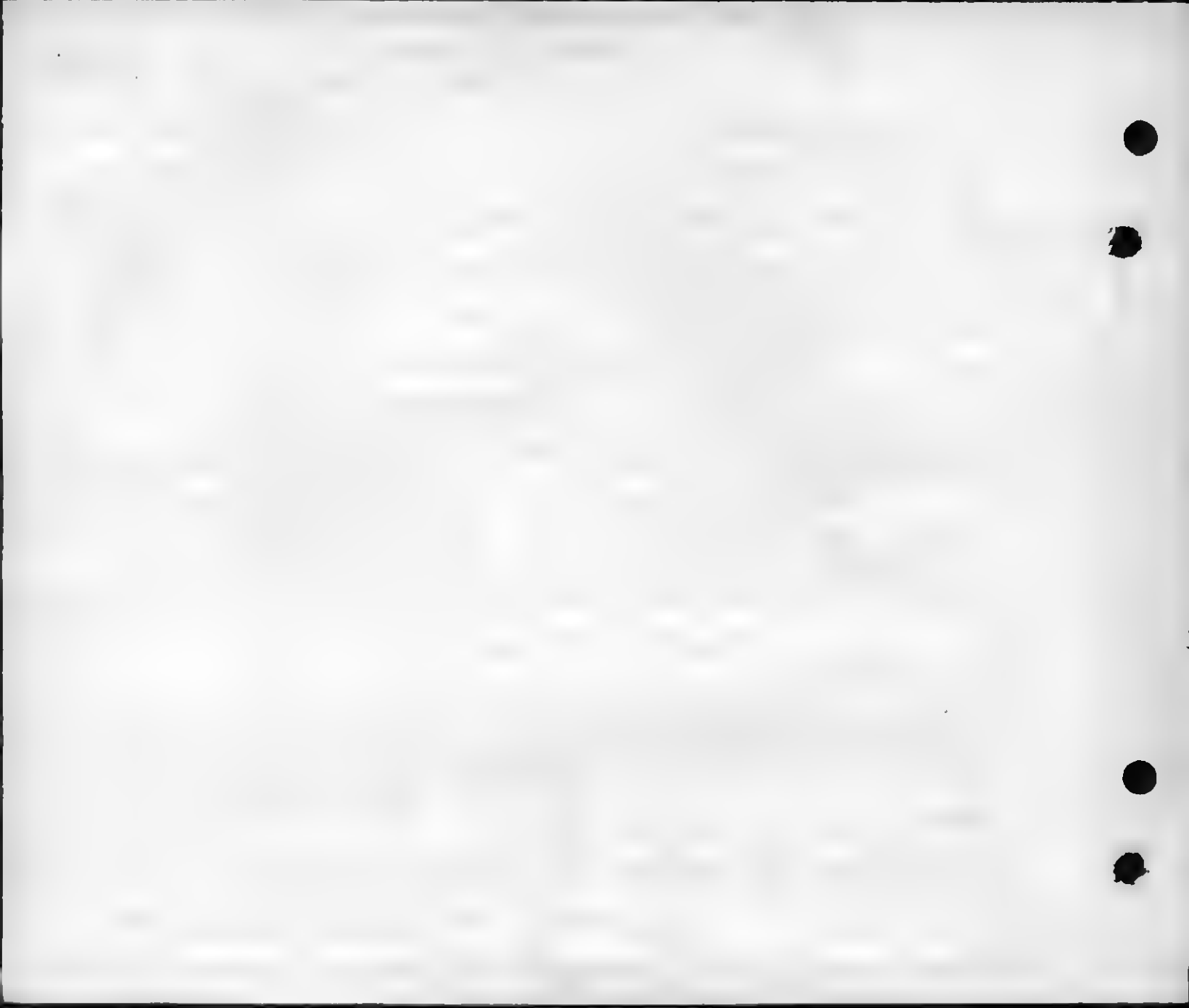
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2½ years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home				d. STREET ADDRESS RFD Woodbine			
3. NAME OF DECEASED (Type or print) First Victoria Middle Mae Last Gilliss				4. DATE OF DEATH Month March Day 11 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1880	
9. AGE (In years last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Lewis				14. MOTHER'S MAIDEN NAME Mattie V. Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs Evelyn M. Eyler, Woodbine, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart, arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). (b) breast cancer, carcinoma fibroblastum, DUE TO (c) diabetes, and hypertension,						INTERVAL BETWEEN ONSET AND DEATH 1958 to 1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1958 , 19 to 11 March, 1961 , that I last saw the deceased alive on 11 March, 1961 , and that death occurred at 11:00 P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE Howard E. Hall				ADDRESS (Street, city or town, state) Damascus, Md.			
DATE SIGNED 11 March 61							
PHYSICIAN'S NAME (Type) Howard E. Hall							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1961		22c. NAME OF CEMETERY OR CREMATORY Poplar Springs Meth.		22d. LOCATION (City, town, or county) (State) Poplar Springs, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohrman				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE MAR 15 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 02914

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT #4, WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>42 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOOK ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE RUSSELL GLOVER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN L. GLOVER</u>	
14. MOTHER'S MAIDEN NAME <u>VIRGINIA PEEDS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-24-9654</u>		17. INFORMANT <u>Mr. C. R. Myers, Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>Sinus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>90 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH, 1959</u> , to <u>MARCH 7, 1961</u> , that I last saw the deceased alive on <u>MARCH 7, 1961</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Stewart, M.D.</u>		DATE SIGNED <u>3/7/61</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. STEWART</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminister, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminister, Md</u>		24. REC'D BY REGISTRAR DATE <u>MAR 10 1961</u>	
24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 2c,d, 10b & 13 Film G-4 4/6/61 iwk

2932

CERTIFICATE OF DEATH

Reg. Dist. No. 02915

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg/ Baltimore 14, Md. 3-1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Nursing Home		d. STREET ADDRESS 2900 Shirey Avenue /Williams Nursing Home/	
3. NAME OF DECEASED (Type or print) First Anna Middle Rose Last Gotsch		4. DATE OF DEATH Month Mar. Day 29 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1882
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper- retired		10b. KIND OF BUSINESS OR INDUSTRY B.V.D. Co.	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick A. Gotsch	
14. MOTHER'S MAIDEN NAME Marie Gihring		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-10-4524A		17. INFORMANT Address Rev. C.W. Jordan, 3525 Hayward Ave., Balto. 15	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Arteriosclerotic C-V Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 wk. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-17-58 , 19____, to 3-29-61 , 19____, that I last saw the deceased alive on 3-28-61 , 19____, and that death occurred at 12:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-29-61			
ACTUAL SIGNATURE D. D. Caples		M.D. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-1-61	22c. NAME OF CEMETERY OR CREMATORY St. Matthews	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE APR 3 1961	
24b. REGISTRAR'S SIGNATURE Charles J. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2933

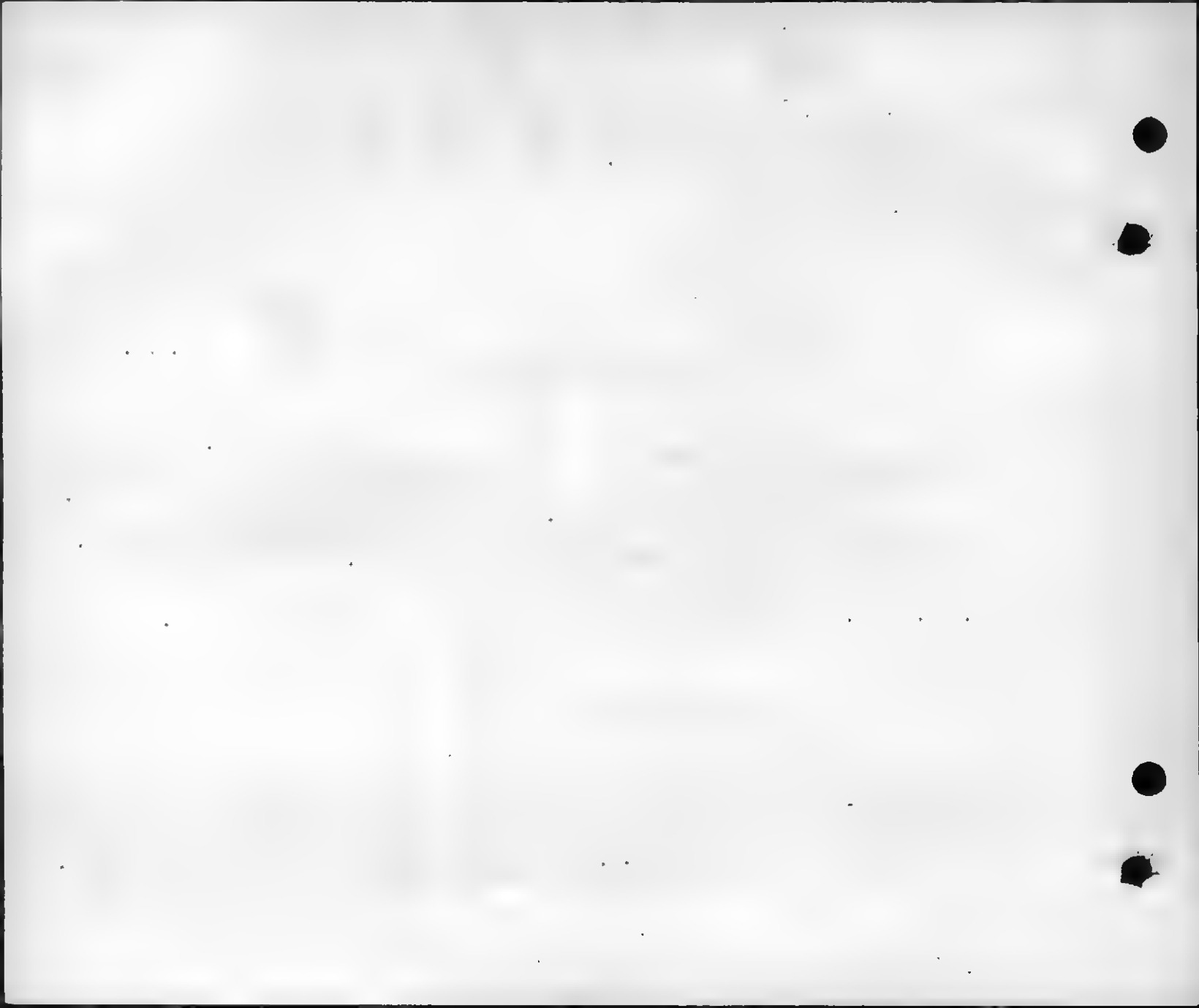
CERTIFICATE OF DEATH

02916

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 11 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Grulich Last Grulich				4. DATE OF DEATH Month March Day 17 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1876		9. AGE (In years last birthday) 84 yrs	10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure due to old extensive myocardial infarction. 420.1 DUE TO (b) Lung abscess with bronchopneumonia following pulmonary artery infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -							INTERVAL BETWEEN ONSET AND DEATH Months. Weeks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 18, 1960 to March 17, 1961 , that (I) (we) last saw the deceased alive on March 16, 1961 , and that death occurred at 1:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/17/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-17-61		23c. NAME OF CEMETERY OR CREMATORY J. W. Lee, Jones		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight Sykesville, Md.				25a. REC'D BY REGISTRAR MAR 21 '61		25b. REGISTRAR'S SIGNATURE William S. Hines	

(M)

(I)



MARYLAND STATE DEPARTMENT OF HEALTH

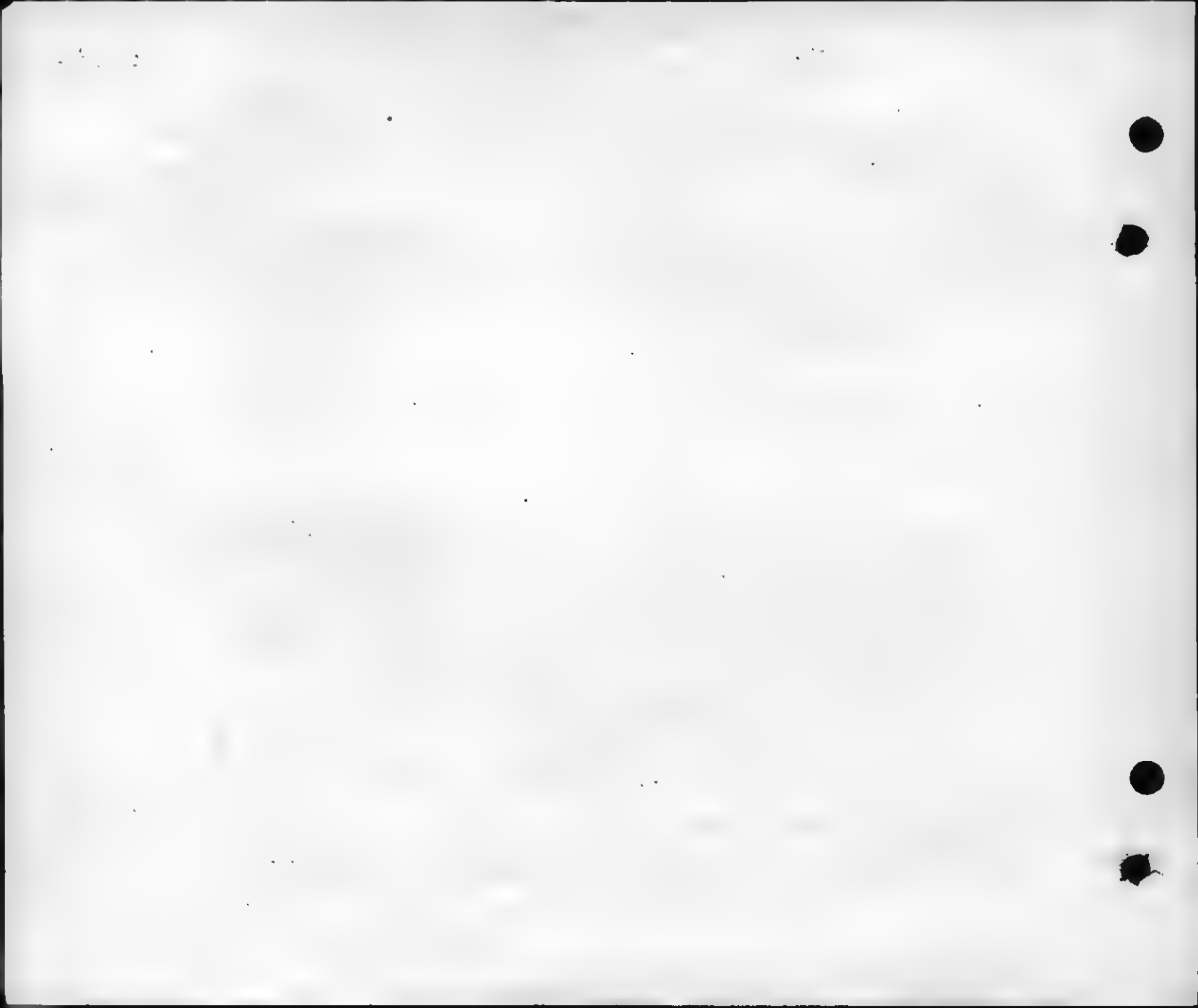
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2934

CERTIFICATE OF DEATH

02917

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Liberty St.</u>				d. STREET ADDRESS <u>412 Liberty St.</u>			
4. DATE OF DEATH First Middle Last <u>GROVER THOMAS HAINES</u>				5. DATE OF DEATH Month Day Year <u>MARCH 28 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5, 1892</u>	
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired meat cutter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Super market</u>			
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas J. Haines</u>				14. MOTHER'S MAIDEN NAME <u>Annie Hyde</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-08-2400</u>			
17. INFORMANT <u>Mrs. Grover J. Haines, Same address</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary sclerosis Hypertension</u> DUE TO (c) <u>arterio sclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Short time</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6, 1956</u> to <u>March 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 27, 1961</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>W. L. Speicher</u> M.D.				22b. DATE <u>3/29/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Westminster Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wentworth Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural New Windsor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>				25. REC'D BY REGISTRAR <u>PR 3 '61</u>			
ADDRESS <u>Westminster Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Carlton S. Haines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



(I)

2935

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02918

Item 1d Film 0203 3/22/61 mh

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>			
c. LENGTH OF STAY IN 1b <u>8 days</u>				d. STREET ADDRESS <u>1 X -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughter's home</u>				e. IS RESIDENCE ONLY A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>W.</u> Last <u>Hammond</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1872</u>	9. AGE (in years lost birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur P. Forsyth</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>218-36-4383</u>		17. INFORMANT Address <u>Mr Robert W. Hammond - Cooksville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>422</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1961</u> , to <u>Mar 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 2, 1961</u> , and that death occurred at <u>7a</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Donnell & Wastin</u> M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Typed) <u>MORRELL N MARTIN</u>				22d. ADDRESS <u>Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Glennwood Heights, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u>	
				DATE <u>MAR 7 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2936

CERTIFICATE OF DEATH

Reg. Dist. No. 02919

1. PLACE OF DEATH a. COUNTY CARROLL Co. Md MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WIMEST NURSING HOME		d. STREET ADDRESS 900 Poplar Grove St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle HELFRICH Last HELFRICH		4. DATE OF DEATH Month March Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1880
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR: Months 3 Days 20 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Helfrich		14. MOTHER'S MAIDEN NAME Philomena	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. X	
17. INFORMANT X		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General debility-invariant 444X DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Bled aqz (b) X (c) X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X			
INTERVAL BETWEEN ONSET AND DEATH 3 mrs franc franc			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. X 19 p. m. X		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) X (County) (State)	
21. I certify that I attended the deceased from 1849 , 19 6-5-1961 , to 3-6-1961 , that I last saw the deceased alive on 3-5-1961 , and that death occurred at 4 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. C. Stone		ADDRESS (Street, city or town, state) Westminster Md	
PHYSICIAN'S NAME (Type) R. C. Stone		DATE SIGNED mg	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-8-61	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		22d. LOCATION (City, town, or county) Balto Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin - 1902 Center Place		24a. REC'D BY REGISTRAR DATE MAR 9 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director.

2937

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

02920

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 120 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Last Jenkins				4. DATE OF DEATH Month March Day 30 Year 1961			
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1905	
9. AGE (In years last birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Groomer				10b KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Lexington, Kentucky				12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arthur Jenkins				14 MOTHER'S MAIDEN NAME Mary McClure			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17 INFORMANT Robert Jenkins - Patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Profused Hemorrhage DUE TO (b) Far adv. pulm. tbc. with a cavity right DUE TO (c) Far adv. pulm. tbc. with a cavity right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 11-30-1960 to 3-30-1961 that (I) (we) last saw the deceased alive on 3-30-1961 , and that death occurred at 9:35 a.m. from the causes and on the date stated above							
22a. SIGNATURE <i>Edgars M. Maculans</i>				22b. DATE SIGNED 3-30-61			
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.				22d. ADDRESS Henryton State Hospital, Henryton, Md.			
23a. BURIAL CREMATION REMOVAL (Spec. fy)		23b. DATE THEREOF 3-31-61		23c. NAME OF CEMETERY OR CREMATORY Crematory Board		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Fran H. Newell</i>				25a. REC'D BY REGISTRAR DATE APR 5 '61			
25b. REGISTRAR'S SIGNATURE <i>W. H. S. Evans</i>							

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MARYLAND STATE DEPARTMENT OF HEALTH

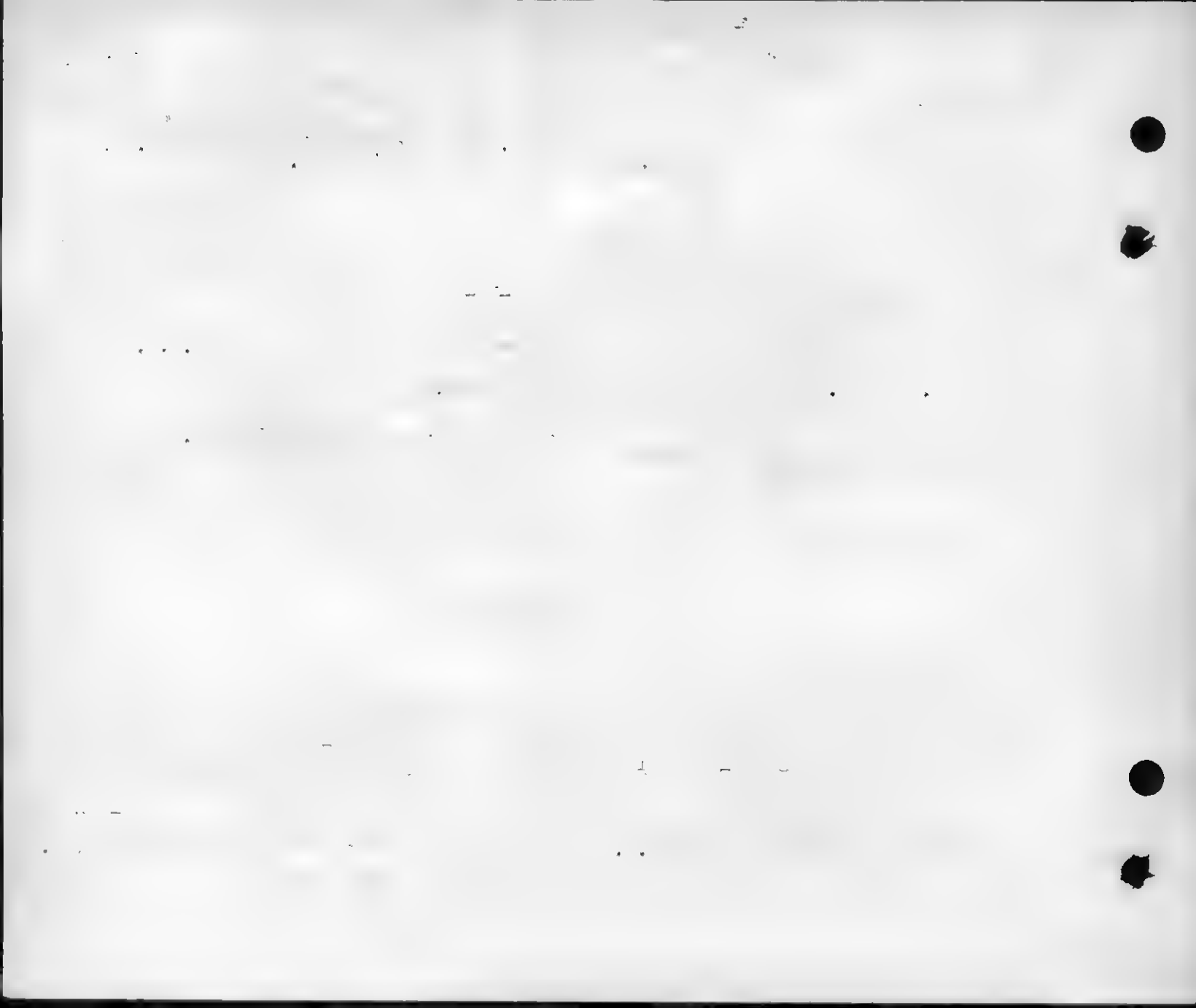
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2938

CERTIFICATE OF DEATH

02921

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs.20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mrs. Pearl Thompson niece of the deceased Box 388 Knoxville Md.			
4. DATE OF DEATH Month March Day 30 Year 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Russell Last Jones							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME William T. Jones				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephro-sclerosis. 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency, Idiopathic, Severe. Bronchopneumonia. (days) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) March 7 1961 3-30 1961 21. I certify that (I) (this hospital) attended the deceased from March 7 1961 to 3-30 1961 , that (I) (we) last saw the deceased alive on 3-30-1961 , and that death occurred at 10P M, from the causes and on the date stated above. 22a. SIGNATURE Agustin del Campo M.D. 22b. DATE SIGNED 3-31-1961 22c. PHYSICIAN'S NAME (Type) Agustin del Campo M.D. 22d. ADDRESS Springfield State Hospital Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 23, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Luke's		23d. LOCATION (City, town, or county) (State) Brownsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE B. Lee Lee				25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE Clara A. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,9 Film 22.2 3-14-61 et

2939

CERTIFICATE OF DEATH

Reg. Dist. No. 02922

1. PLACE OF DEATH a. COUNTY <u>CARROLL Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>---</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>MABLE</u> Last <u>WONS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FREDERICK Co. MD</u>	
11. BIRTHPLACE (State or foreign country) <u>FREDERICK Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>Michael FLOHN</u>		14. MOTHER'S MAIDEN NAME <u>MARY E FCKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>RUSSEL BOHN</u>		Address <u>Key MAR. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>---</u> <u>---</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3</u> , 19 <u>61</u> , to <u>---</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>61</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Canicopa</u>		ADDRESS (Street, city or town, state) <u>---</u>	
PHYSICIAN'S NAME (Type) <u>---</u>		DATE SIGNED <u>3/3/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-6-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>(New) Uniontown MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond K Wright</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '61</u>	
ADDRESS <u>Union Bridge MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by a physician or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 11/58

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2941

CERTIFICATE OF DEATH

02924

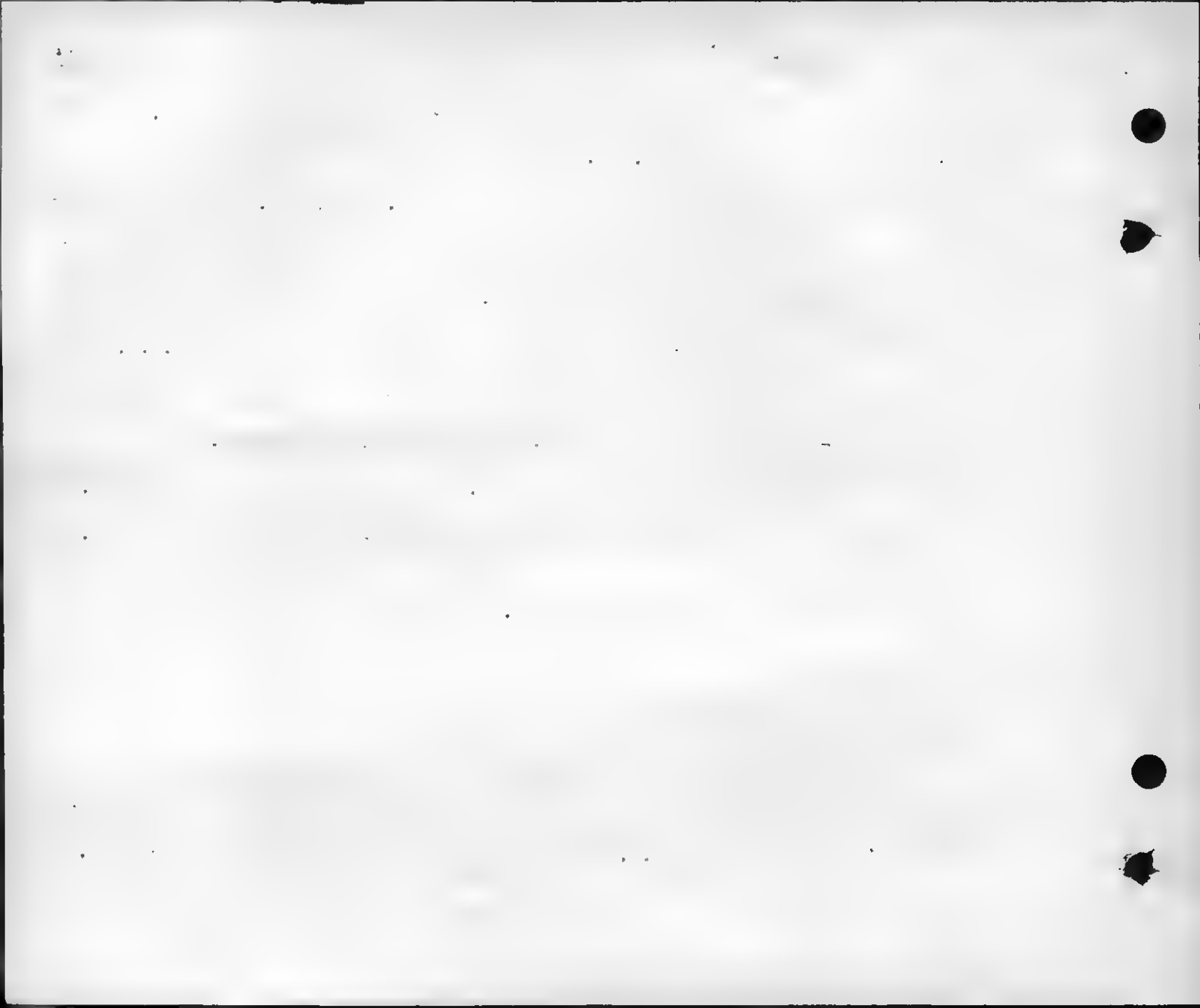
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 48yrs.1mo.17days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1430 E. Fayette St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle Kropman Last Kropman		4. DATE OF DEATH Month March Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1891
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 5 Days 10	11. IF UNDER 24 HRS Hours 10 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Kropman		14. MOTHER'S MAIDEN NAME Edith -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address -	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) Schizophrenic reaction, hebephrenic type.		INTERVAL BETWEEN ONSET AND DEATH XXXXX Hours XXXXX Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month March Day 7 Year 1966 Hour 6:35 PM a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto. Md. (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 7, 1966 to March 9, 1961 , that (I) (we) last saw the deceased alive on March 9, 1961 , and that death occurred on March 9, 1961 from the causes and on the date stated above.	
22a. SIGNATURE Agustin del Campo. M.D.	22b. DATE SIGNED 3/9/61
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	22d. ADDRESS Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/61	23c. NAME OF CEMETERY OR CREMATORY St. Shalom	23d. LOCATION (City, town, or county) (State) Balto. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ed. Russell Gibson Jr. Co. of Baltimore		25a. REC'D BY REGISTRAR DATE MAR 13 '61	25b. REGISTRAR'S SIGNATURE Charles E. Thomas

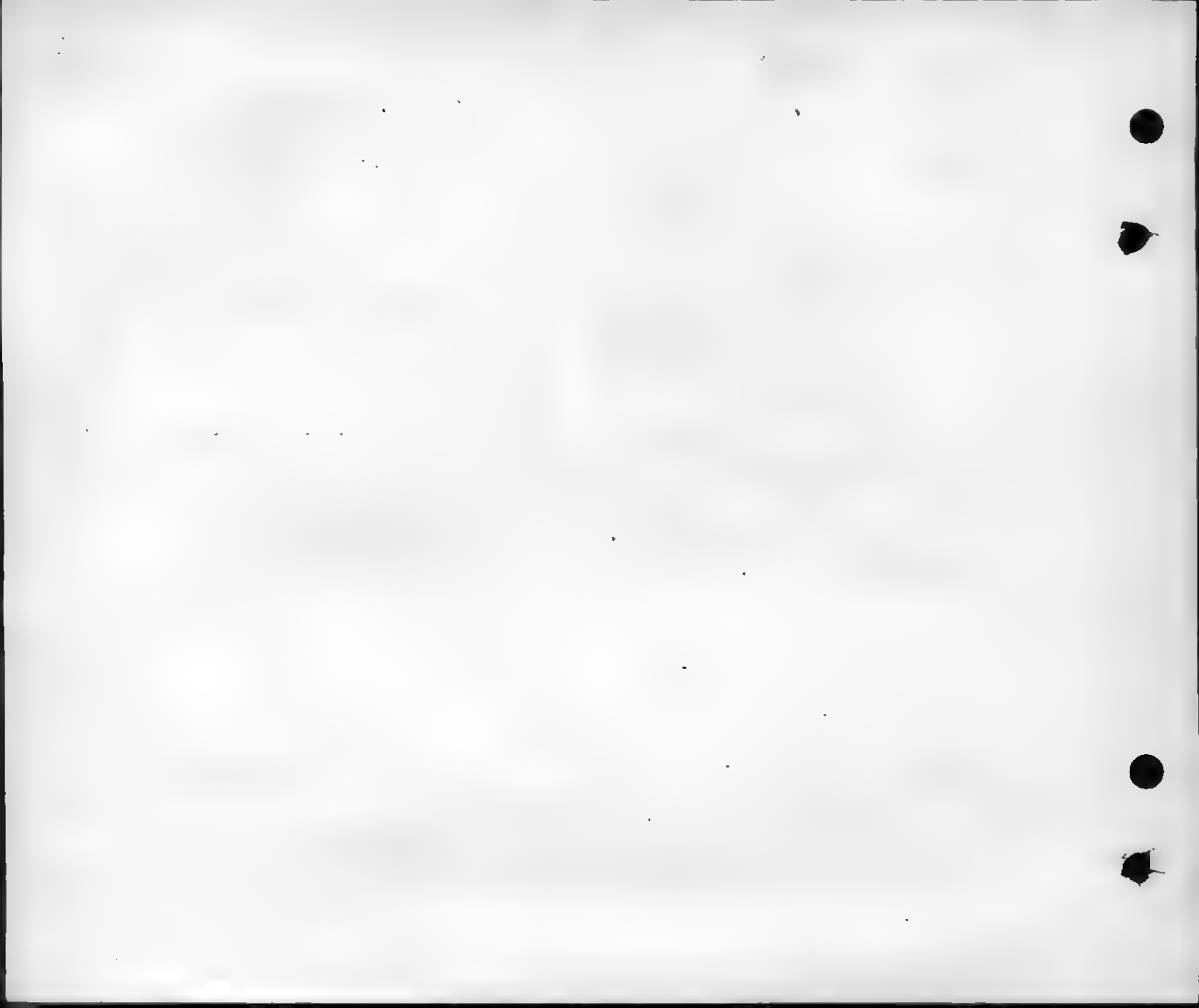


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2942

02925

1 PLACE OF DEATH a. COUNTY <u>Harrell</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harrell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA - E - LEATHER</u>				4. DATE OF DEATH Month Day Year <u>Mar 24 1961</u>			
5. SEX <u>FA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-1873</u>		9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Worker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>210</u>		17. INFORMANT Address <u>Mrs Leona Campbell - Boung 7th</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 743X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>Atherosclerosis Generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> 19 <u>54</u> to <u>Mar 23</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 23</u> 19 <u>61</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
22a SIGNATURE <u>Joseph E. Bush MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>3/24/61</u>	
22c PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d ADDRESS <u>Hampstead Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-26-61</u>		<u>Wesley</u>		<u>Harrell Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Lepton - Hampstead Md</u>				ADDRESS <u>Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 28 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

2943

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02926

1. PLACE OF DEATH a. COUNTY <u>Harrell</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manassas</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harrell</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manassas</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES - A - LEESE</u> First Middle Last		4. DATE OF DEATH <u>March 20</u> Month Day Year		19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3 - 1920</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR: Months Days Hours IF UNDER 24 HRS: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>IND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Cleveland Leese</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Leese</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-12-0926</u>		17. INFORMANT <u>Mrs Hazel Leese - Manassas Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Cor Pulmonale</u> (b) <u>Fibrosis of Lungs</u> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>4 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>October 1956</u> to <u>March 20 1961</u> , that (I) (we) last saw the deceased alive on <u>March 19 1961</u> , and that death occurred at <u>5 a.m.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>M. C. Porterfield M.D.</u>		22b. ADDRESS <u>Hampstead, Md</u>		22c. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>					
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF <u>3-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Manassas</u>	23d. LOCATION (City, town, or county) <u>Harrell Md</u>	(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u>		25a. REC'D BY REGISTRAR <u>MAR 23 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



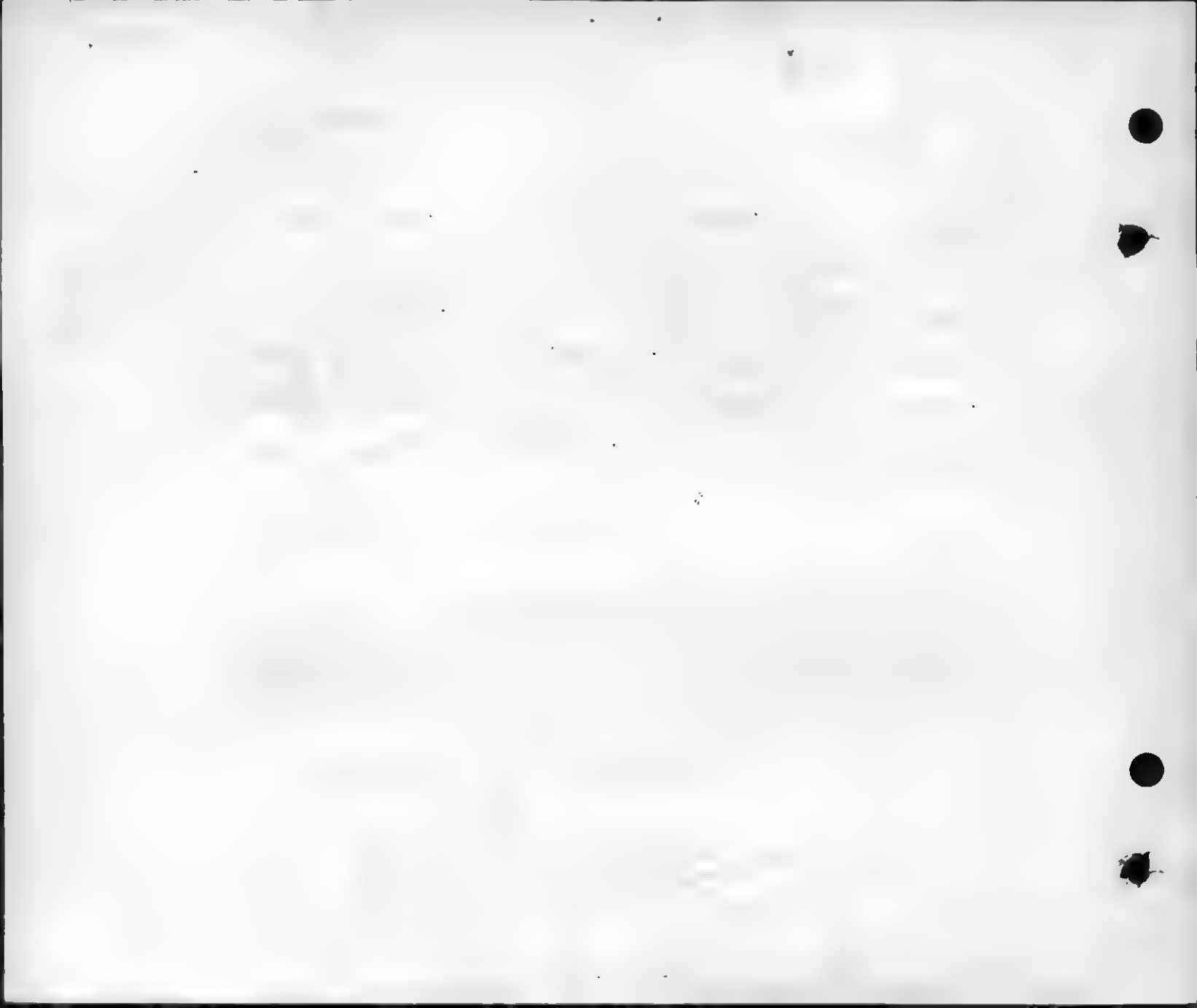
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician or the funeral director. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2944
CERTIFICATE OF DEATH

02927

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>89 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carrollton</u>				d. STREET ADDRESS <u>Carrollton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NOAH JACKSON LONG</u>				4. DATE OF DEATH Month Day Year <u>MARCH 15 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15 1871</u>	
9. AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed Carroll Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
13. FATHER'S NAME <u>Willis L. Long</u>				14. MOTHER'S MAIDEN NAME <u>Betty Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>42-01-8701</u>		17. INFORMANT <u>William L. Stewart, M.D.</u> Address <u>1921066 RD. 4 Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/12 1961</u> to <u>3/15 1961</u> , that (I) (we) last saw the deceased alive on <u>3/14 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William L. Stewart, M.D.</u>				22b. DATE SIGNED <u>3/15/61</u>		22c. PHYSICIAN'S NAME (Type) <u>WILLIAM L. STEWART, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Carrollton Md.</u>				23e. REC'D BY REGISTRAR DATE <u>MAR 21 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer</u> ADDRESS <u>Westminster, Md.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

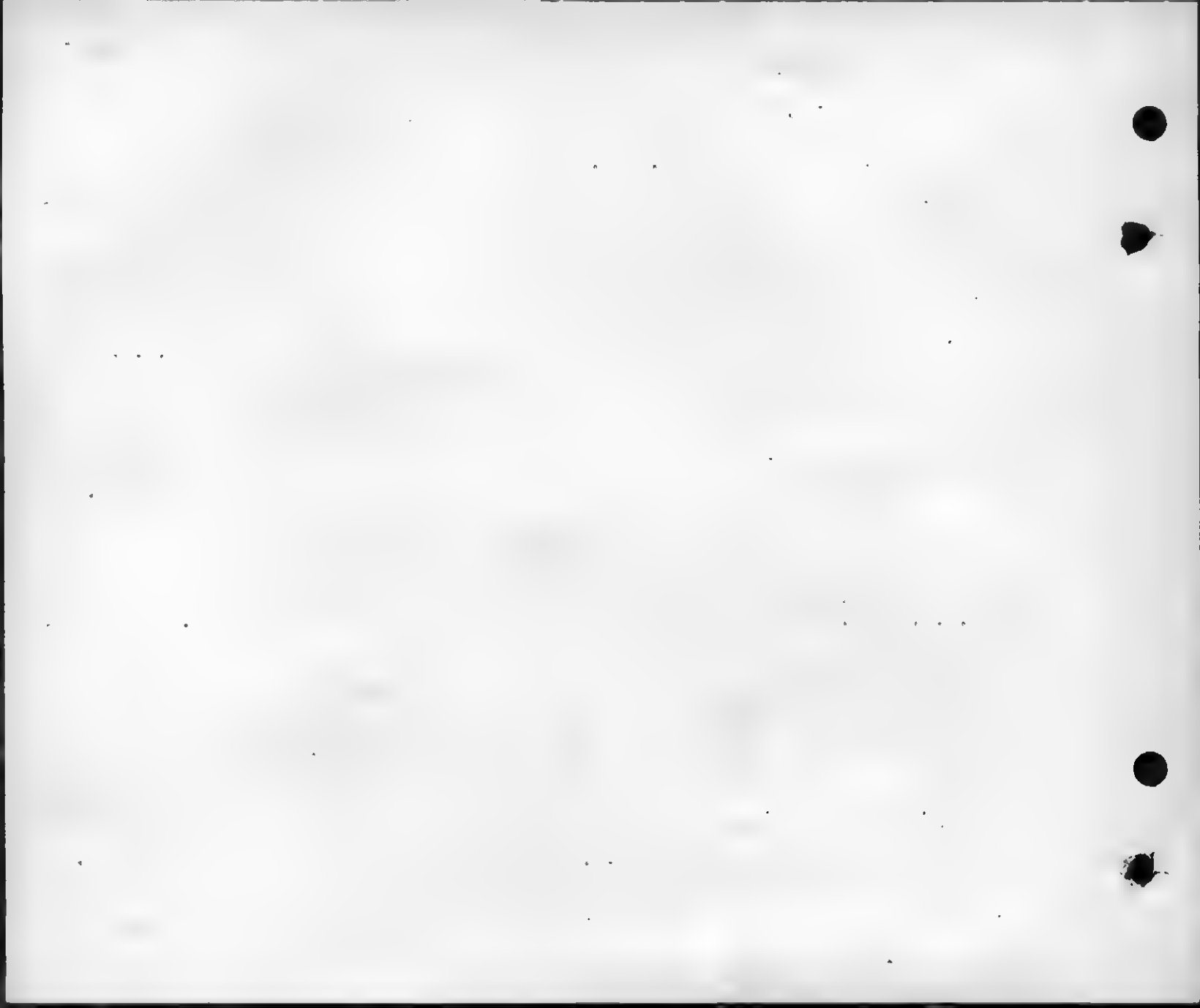
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2945

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02928

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4524 Mainfield Avenue	
3. NAME OF DECEASED (Type or print) First Charles Middle Thomas Last Lusco		4. DATE OF DEATH Month March Day 12, Year 1961	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1872
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lusco		14. MOTHER'S MAIDEN NAME Ann Culotta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Days.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1959 to March 12, 1961 that (I) (we) last saw the deceased alive on March 12, 1961 and that death occurred at 11:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE 3/13/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/16/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Old Frederick Rd. Balto. 29-Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Larue Inc. 712-14 E. North Ave. Balto. 2-Md.		25. ADDRESS 712-14 E. North Ave. Balto. 2-Md.	



CERTIFICATE OF DEATH

Reg. Dist. No.

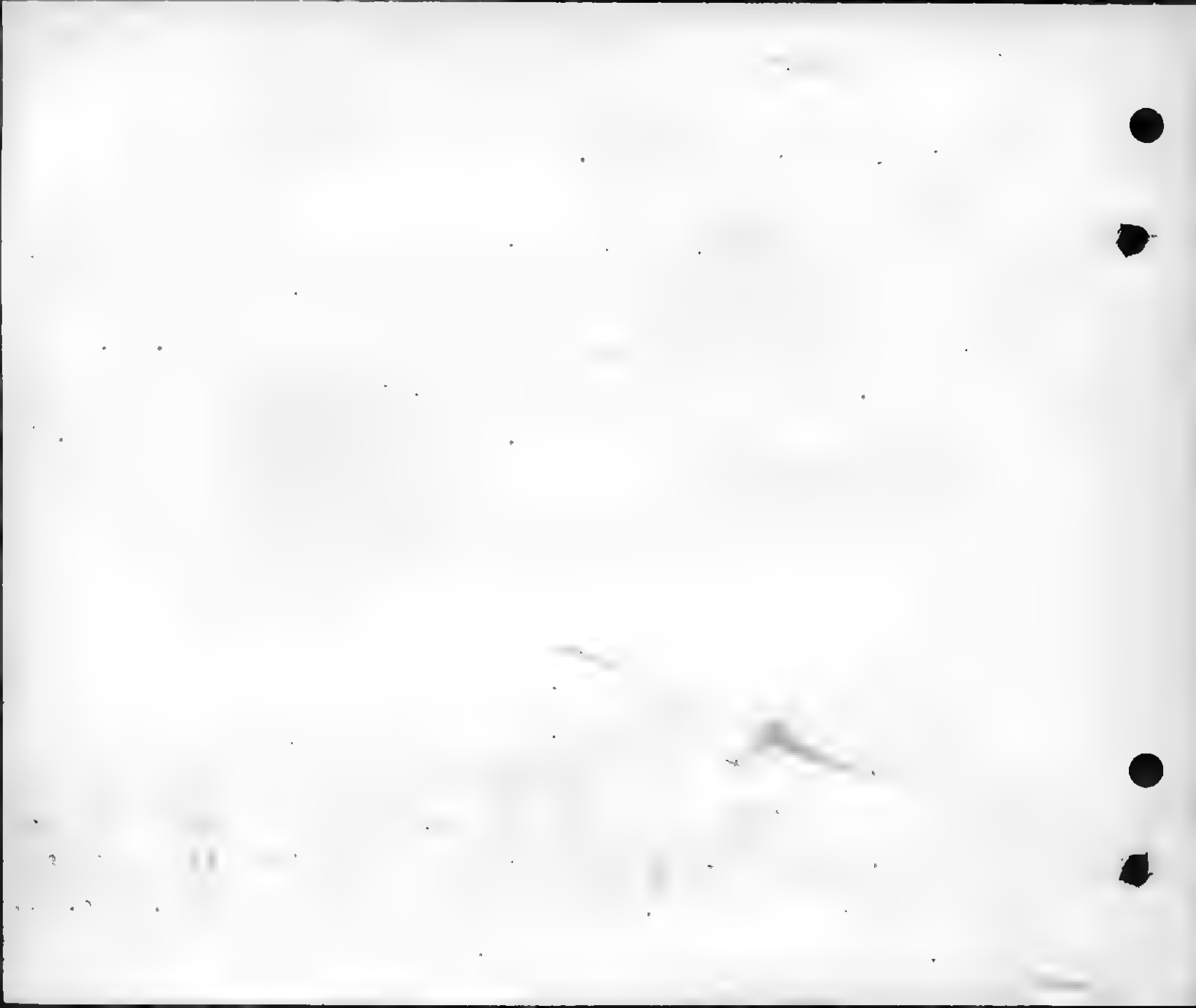
02929

2946

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor rural		c. LENGTH OF STAY IN 1b 3 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home of daughter		d. STREET ADDRESS Rocky Ridge	
3. NAME OF DECEASED (Type or print) First IVY Middle MAY Last MARSHALL		4. DATE OF DEATH Month March Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1883
9. AGE (In years last birthday) yrs 77		10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min 61	11. IF UNDER 24 HRS. Months 7 Days 12 Hours 19 Min 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Wood		14. MOTHER'S MAIDEN NAME Amanda Speak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
INFORMANT Mrs. Robert Wisner		Address New Windsor, Md. RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic C.V.D. and DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 9/13/60 , 19____, to 3/12/61 , 19____, that I last saw the deceased alive on 3/6/61 , 19____, and that death occurred at 11:43 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M.E. Robertson		ADDRESS (Street, city or town, state) New Windsor, Md. DATE SIGNED 3/13/61	
PHYSICIAN'S NAME (Type) M.E. Robertson		New Windsor, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-15-61	22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery	22d. LOCATION (City, town, or county) (State) Rocky Ridge, Md. Fred. Co.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE MAR 16 '61
		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the funeral director or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

283
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02930

1. PLACE OF DEATH
a. COUNTY **Carroll** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **NEW WINDSOR RURAL YEARS**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **RT 2**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Carroll**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **New Windsor**
d. STREET ADDRESS **Rt.#2**

3. NAME OF DECEASED (Type or print) **Mary Anna May McKinney**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **March 17, 1961**
WIDOWED ☐ DIVORCED ☐ **APRIL 18 - 1924** 36 yrs. 9. AGE (In years last birthday) **36** 10. IF UNDER 1 YEAR: Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10b. KIND OF BUSINESS OR INDUSTRY **OWN HOME** 11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **JOSEPH CLICK** 14. MOTHER'S MAIDEN NAME **ANNIE ECKENRODE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **NO** 16. SOCIAL SECURITY NO. **24-16 0939** 17. INFORMANT **RAYMOND MCKINNEY NEW WINDSOR MD**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Gunshot wound of head.**
976X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot self in head

20c. TIME OF INJURY Month, Day, Year **8/17/61** 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ home ☐ factory, street, office bldg., etc.)
Hour, a.m. **1:00** a.m. **8/17/61**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **William V. Lovitt, Jr., M.D.** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **William V. Lovitt, Jr., M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **March 18, 1961**
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 22b. DATE THEREOF **3/20/61** 22c. NAME OF CEMETERY OR CREMATORY **PIPE CREEK** 22d. LOCATION (City, town, or country) (State) **CARROLL CO MD**

23. FUNERAL DIRECTOR **Dr. Hartzler & Sons New Windsor Md** ADDRESS **New Windsor Md** 24a. REC'D BY REGISTRAR **MAR 21 '61** 24b. REGISTRAR'S SIGNATURE **William S. Thomas**



CERTIFICATE OF DEATH

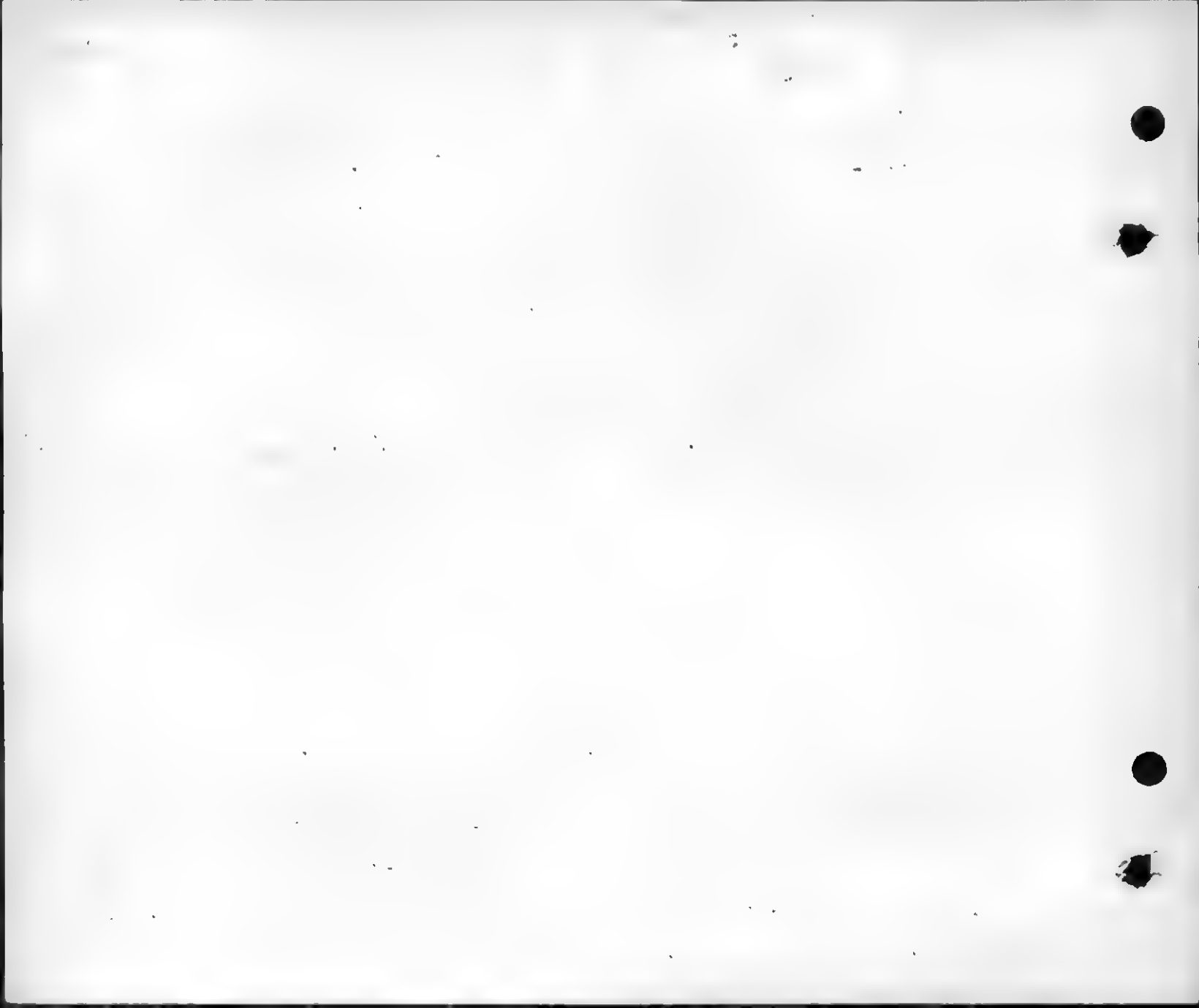
Reg. Dist. No. 02931

2948

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LINWOOD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEARLIE</u> <u>ETTA</u> <u>MUNFORD</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>11</u> <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 30 - 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>D. E. WEBB</u>		14. MOTHER'S MAIDEN NAME <u>ALICE LOVELACE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>WINFORD MUNFORD</u> Address <u>UNION BRIDGE MD</u>		18. RURAL <input checked="" type="checkbox"/> URBAN <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20e. (City or town) _____ (County) _____ (State) _____		20f. _____	
21. I certify that I attended the deceased from <u>8/11/59</u> , 19__ to <u>3/11/61</u> , 19__, that I last saw the deceased alive on <u>3/10/61</u> , 19__, and that death occurred at <u>11:10</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D. <u>New Windsor, Md.</u> DATE SIGNED <u>3/11/61</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u> <u>NEW WINDSOR MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 14 - 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>SHELBY N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons New Windsor, Md</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>MAR 14 '61</u> DATE _____	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		24c. _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



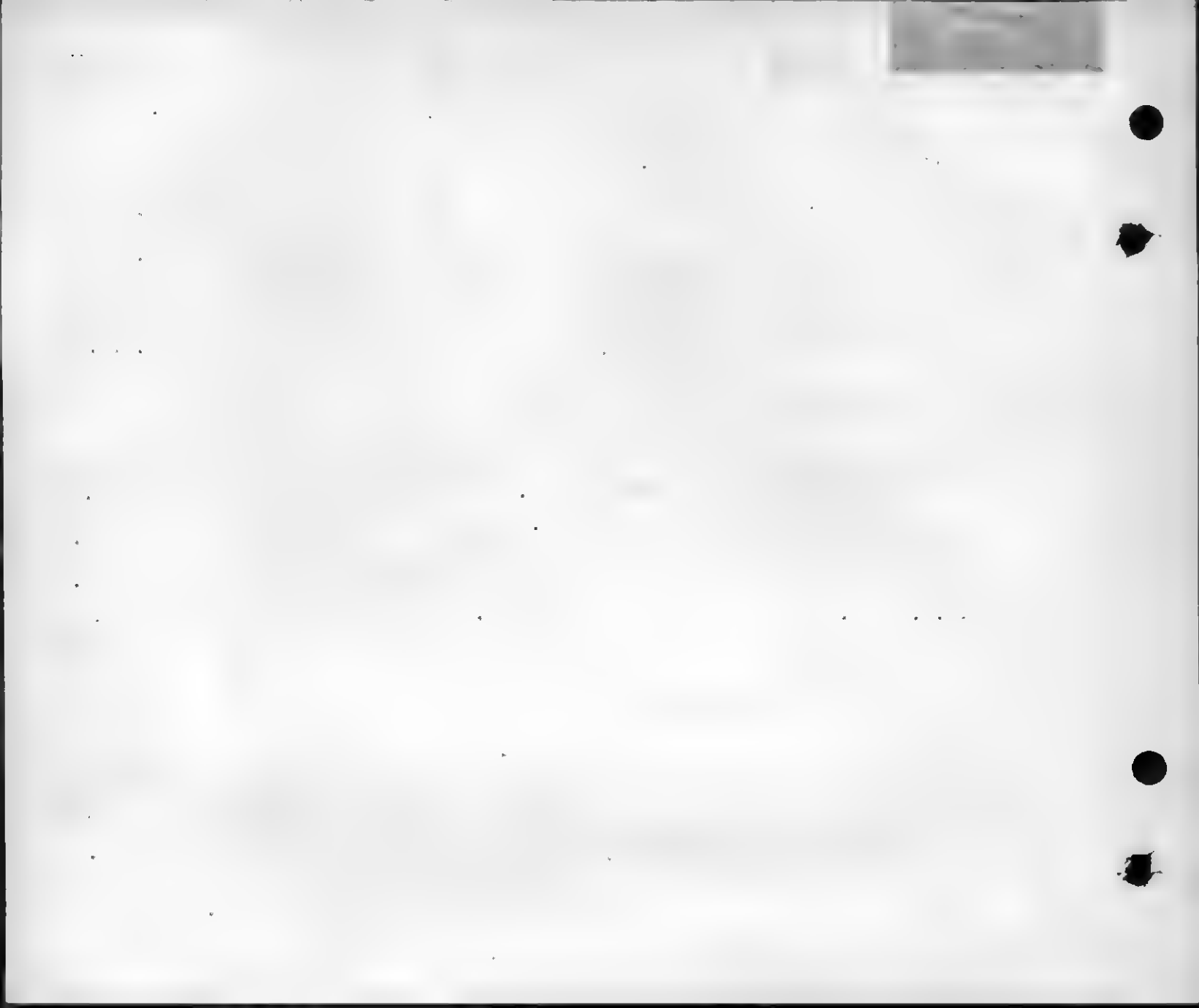
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2949

02932

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS Wesley Chapel and Gerting Rds.	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Bartholdt Last Nicoll		4. DATE OF DEATH Month March Day 8 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1879
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 15 Min 0	11. IF UNDER 24 HRS. Hours 15 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Rd.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William James Nicoll	
14. MOTHER'S MAIDEN NAME Annie Bartholdt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-07-1961		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Old myocardial infarct DUE TO (c) Arteriosclerotic heart disease.			INTERVAL BETWEEN ONSET AND DEATH Days. Years. Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 31, 1961 to March 8, 1961 that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 12:45 AM on the causes and on the date stated above			
22a. SIGNATURE <i>Agustin del Campo</i> M.D.		22b. DATE SIGNED 3/8/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 3-11-61	23c. NAME OF CEMETERY OR CREMATORY St. James Episcopal	23d. LOCATION (City, town, or county) (State) Monkton, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		25a. REC'D BY REGISTRAR DATE MAR 10 '61	
25b. REGISTRAR'S SIGNATURE <i>W. A. D. Thoms</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2950

CERTIFICATE OF DEATH

02933

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2701 Ashland Avenue	
3. NAME OF DECEASED (Type or print) First James Middle Novak Last Novak		4. DATE OF DEATH Month March Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1871
9. AGE (In years lost birthday) yrs. 89		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Novak		14. MOTHER'S MAIDEN NAME Katrina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate and bladder. DUE TO 199X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic heart disease. DUE TO (c) Multiple abscess of right kidney. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): C.B.S. associated with senile psychosis.			
INTERVAL BETWEEN ONSET AND DEATH Months Years. Weeks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 9, 1961 to March 24, 1961 , that (I) (we) last saw the deceased alive on March 24, 1961 , and that death occurred at 10:40AM from the causes and on the date stated above			
22a. SIGNATURE <i>Agustin del Campo</i>		22b. DATE 3/24/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/28/61	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>		25c. DATE MAR 28 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

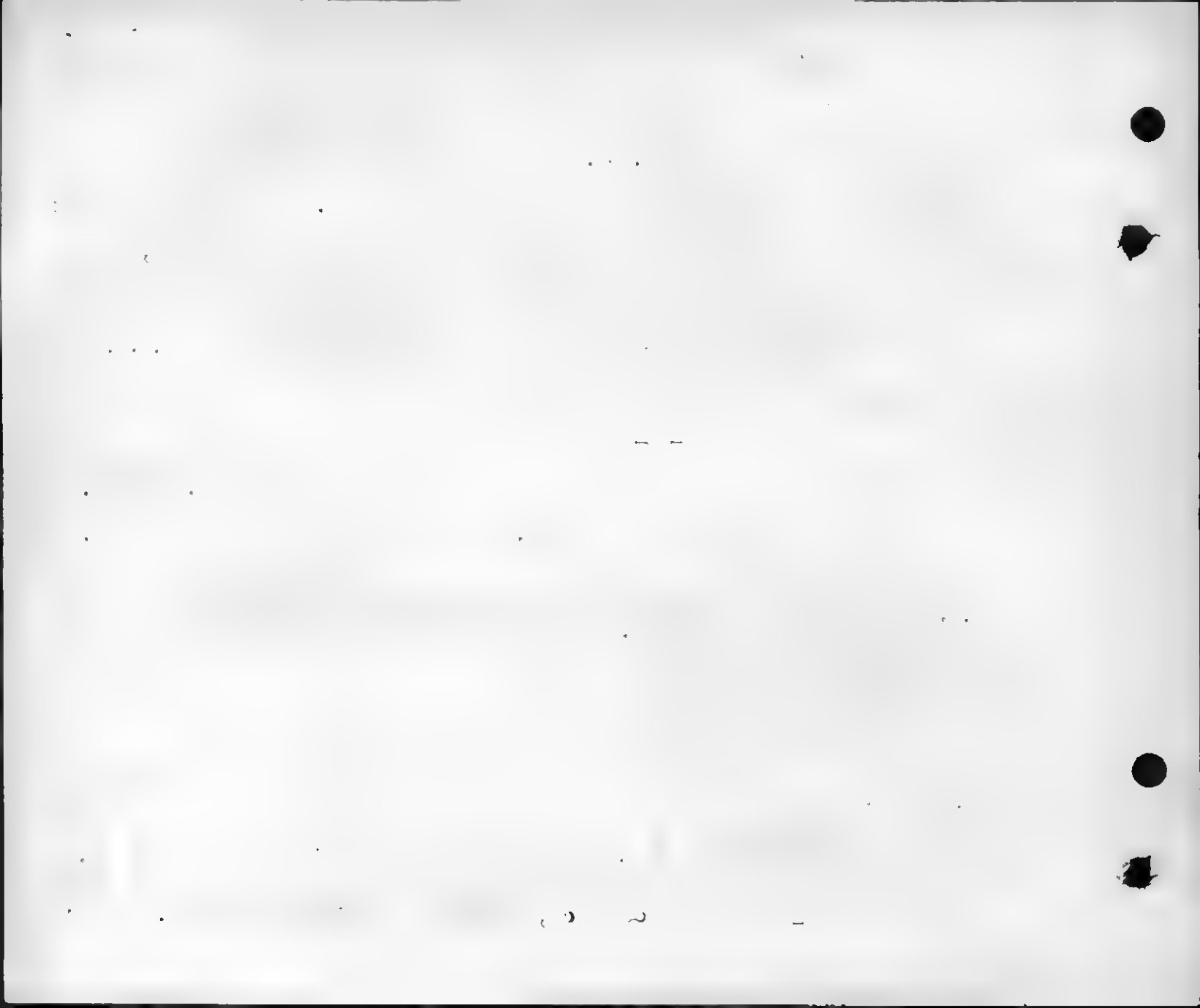
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2951

02934

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 1011	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. Springfield State Hospital		d. STREET ADDRESS 5 Hamilton Ave.	
3. NAME OF DECEASED (Type or print) First George Middle Potts Last Potts		4. DATE OF DEATH Month March Day 6 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 1, 1888
9. AGE (in years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Potts		14. MOTHER'S MAIDEN NAME Elizabeth Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO 214-10-4777	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive hemorrhage from chronic duodenal ulcer. 757.1 DUE TO (b) Polycystic kidneys. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with central nervous system syphilis, meningoencephalitic, with psychotic reaction. INTERVAL BETWEEN ONSET AND DEATH Hours. Years.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to March 6, 1961 , that (I) (we) last saw the deceased alive on March 6, 1961 , and that death occurred at M , from the causes and on the date stated above			
22a. SIGNATURE Agustin del Campo M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE 3/6/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-8-1961	23c. NAME OF CEMETERY OR CREMATORY XXXX Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) Lagore, Frederick Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey Jr. Frederick Md.		25. REC'D BY REGISTRAR MAR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2952
02935
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 4545 N. Charles Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARSHALL Middle WILSON Last RIDGELY		4. DATE OF DEATH Month 3 Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-94
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Private-Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter B. Ridgely, dec.		14. MOTHER'S MAIDEN NAME Blanche M. Hurtt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-03-0655	
17. ADDRESS Mr. Marshall W. Ridgely-4545 N. Charles St. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO 20.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis without 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-8-60 19____, to _____ 19____, that (I) (we) last saw the deceased alive on 3/24/61 19____, and that death occurred at 6A M, from the causes and on the date stated above			
22a. SIGNATURE Gertrude M. Gross, M.D.		22b. DATE SIGNED 3/24/61	
22c. PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-61	
23c. NAME OF CEMETERY OR CREMATORY Old Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Oakland Mills, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Knaus		25a. REC'D BY REGISTRAR MAR 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			



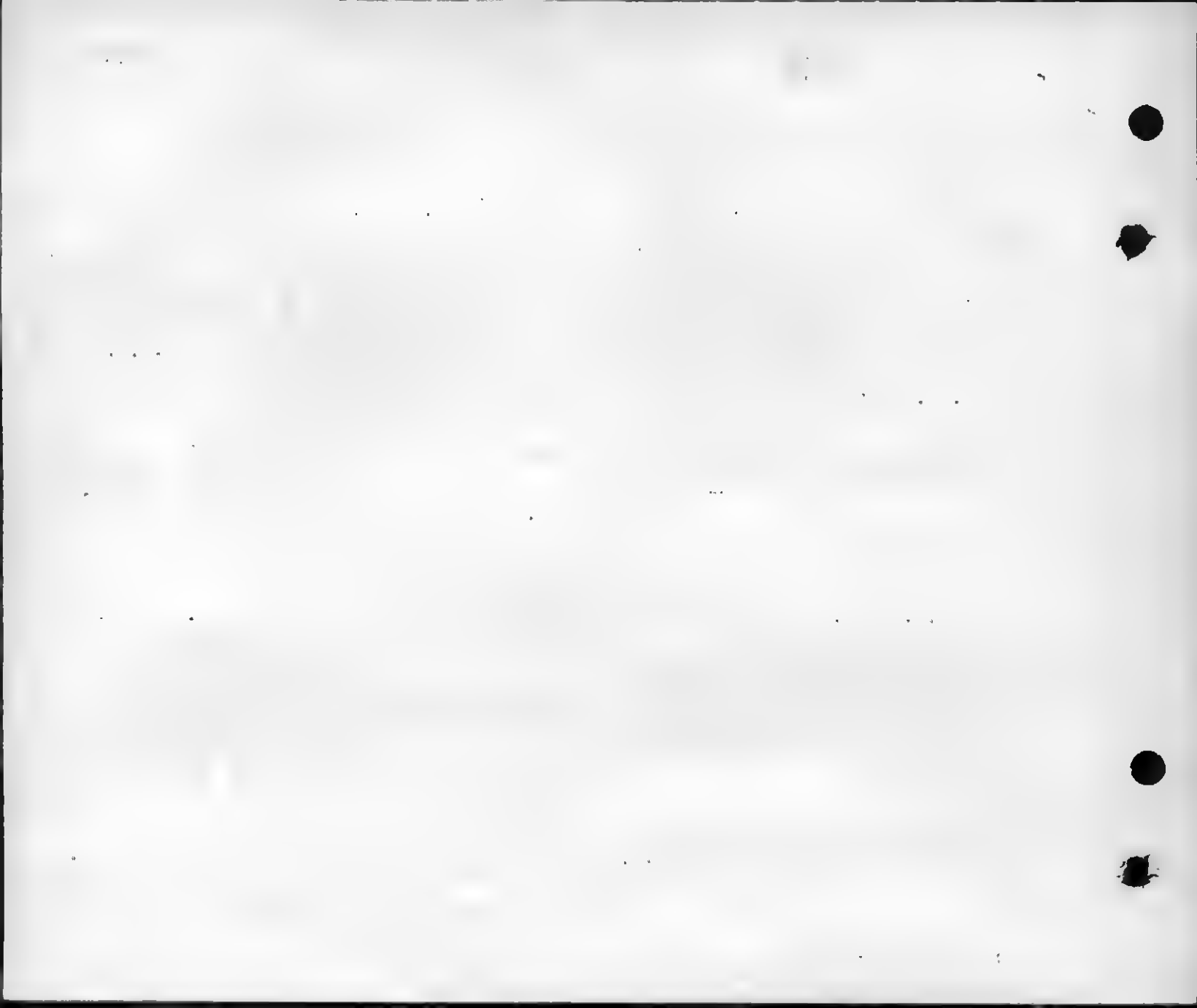
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2953

02936

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b COUNTY Montgomery ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb 1 mo. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring IS X-2			
f. STREET ADDRESS 571 E. University Lane				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Myra Leigh Minor Riley				4. DATE OF DEATH Month Day Year March 8, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1875	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min		11. IF UNDER 24 HRS: Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME W. D. Minor				14. MOTHER'S MAIDEN NAME Julia -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 577-05-7811A		17. INFORMANT Address Springfield Hospital Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent bronchopneumonia due to staphylococcus. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Days.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 30, 1961 to March 8, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 12:30 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustin del Campo</i> M.D.				22b. DATE SIGNED 3/8/61		22c. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE MAR 10 '61		25b. REGISTRAR'S SIGNATURE <i>James S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It is to be signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2954

02937

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Albert Middle Eugene Last Rippelmeyer				4. DATE OF DEATH Month March Day 10, Year 19 61			
5. SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH January 21, 1883	
9 AGE (In years, lost birthday) 78 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales manager		10b KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Missouri	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Frederick Rippelmeyer		14. MOTHER'S MAIDEN NAME - Maikon Margaret Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. -		17 INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the bladder with metastasis. 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) C.B.S. with senile brain disease.							
INTERVAL BETWEEN ONSET AND DEATH Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. with senile brain disease.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 3/7/55 to March 10, 19 61 , that (I) (we) last saw the deceased alive on March 9, 19 61 and that death occurred at 3:30AM from the causes and on the date stated above.							
22a SIGNATURE Agustin del Campo				22b DATE SIGNED 3/10/61			
22c PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3/13/61		23c NAME OF CEMETERY OR CREMATORY PROSPECT HILL		23d LOCATION (City, town, or county) (State) YORK RD TOWSON MD	
24. FUNERAL DIRECTOR'S SIGNATURE DIPPEL BROS				25a REC'D BY REGISTRAR DATE MAR 13 '61		25b REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS 7110 BELAIR RD							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 11/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2955

02938

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 304 W. Biddle St.	
3. NAME OF DECEASED (Type or print) First Abraham Middle Scherman Last Scherman		4. DATE OF DEATH Month March Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1884
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria ✓	
13. FATHER'S NAME Isaac Scherman		14. MOTHER'S MAIDEN NAME Rachel Siegaltuch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary occlusion DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia.			
INTERVAL BETWEEN ONSET AND DEATH Days Days Years			
19. WAS ALTOGETHER PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 , to March 28, 1961 , that (I) (we) last saw the deceased alive on March 28, 1961 , and that death occurred at 11:55 AM from the causes and on the date stated above			
22a. SIGNATURE Agustini del Campo M.D.		22b. DATE SIGNED 3/28/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61	
23c. NAME OF CEMETERY OR CREMATORY Rosedale		23d. LOCATION (City, town, or county) (State) Balto Md	
24. GENERAL DIRECTOR'S SIGNATURE John Lewis Jr		25a. REC'D BY REGISTRAR March 30 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2956 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>lmo., 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springfield State Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> Washington b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>221 N. Locust St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Alberta Elizabeth Harshman Semler</u>			4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 61</u>		
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>February 11, 1906</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Ira Victor Harshman</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Biddle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Springfield Hospital Records</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Heart failure</u> DUE TO (c) <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pre-senile brain disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>Weeks</u> <u>Years</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James T. Marsh</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4-2-61</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Hagerstown, Md.</u>		
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son Hagerstown, Md.</u>			24a. REC'D BY REGISTRAR <u>APR 3 '61</u>		
24b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

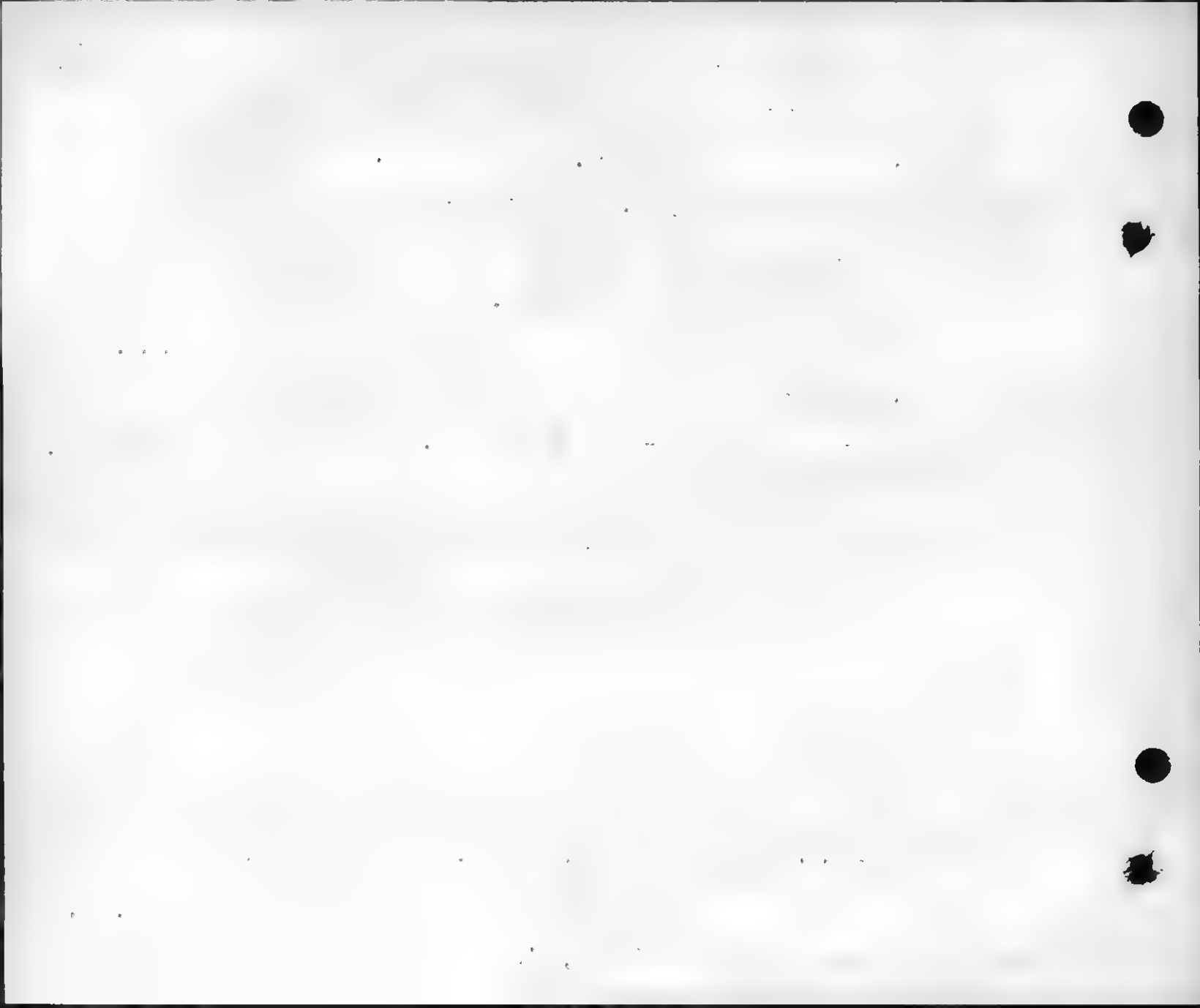
2957

CERTIFICATE OF DEATH

Reg. Dist. No. **02940**

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reese Md.			c. LENGTH OF STAY IN 1b 1yr 3Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reese Md. near Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cable Boarding Home Reese, Md.				d. STREET ADDRESS Old Baltimore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Rhoda Middle May Last Simonson				4. DATE OF DEATH Month March Day 6 Year 19 61				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1884		
9. AGE (In years last birthday) yrs 76		IF UNDER 1 YEAR Months 6 Days 19 Hours 61 Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry H. Hymiller				14. MOTHER'S MAIDEN NAME Martha Waltman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. 220-05-4436D		INFORMANT daughter Mrs. Stanley Green		Address 10 Malcolm Drive Westminster, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO (b) Arterio Sclerosis General Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) General								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb 17, 1961, to March 6, 1961, that I last saw the deceased alive on March 6, 1961, and that death occurred at 10:45 P.M. from the causes and on the date stated above								
ACTUAL SIGNATURE W. G. Speicher Westminster Md.				DATE SIGNED 3/7/61				
PHYSICIAN'S NAME (Type) Dr. W. G. Speicher				135 E. Main St. Westminster, Md.				
22a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/61		22c. NAME OF CEMETERY OR CREMATORY Baust Cemetery		22d. LOCATION (City, town, or county) (State) near Tyrone Carroll Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell				ADDRESS 254 E. Main St. Westminster, Md.		24a. REC'D BY REGISTRAR Mar 8 '61		
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



AD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

02941

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARRETT</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linger's Nursing Home</u>		d. STREET ADDRESS <u>8320 Beryl Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SARAL</u> Middle <u>E</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 11, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nelson Campbell</u>		14. MOTHER'S MAIDEN NAME <u>ALBERTA-RANDALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-8460</u>	
17. INFORMANT <u>Elmer C Koller</u> Address <u>8320 Beryl Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General debility + exhaustion</u>			
(b) <u>Old age +</u>			
(c) <u>Terminal disease of the heart</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>76</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>X</u> 19 <u>61</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1961</u> to <u>3-2-1961</u> , that (I) (we) last saw the deceased alive on <u>3-2-1961</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. C. Stone</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. C. STONE M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, <u>EMERALD</u>		23b. DATE THEREOF <u>3/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS & Son</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
ADDRESS <u>8802 HARFORD RD</u>		25b. REGISTRAR'S SIGNATURE <u>Chas E. Koller</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for additional information. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

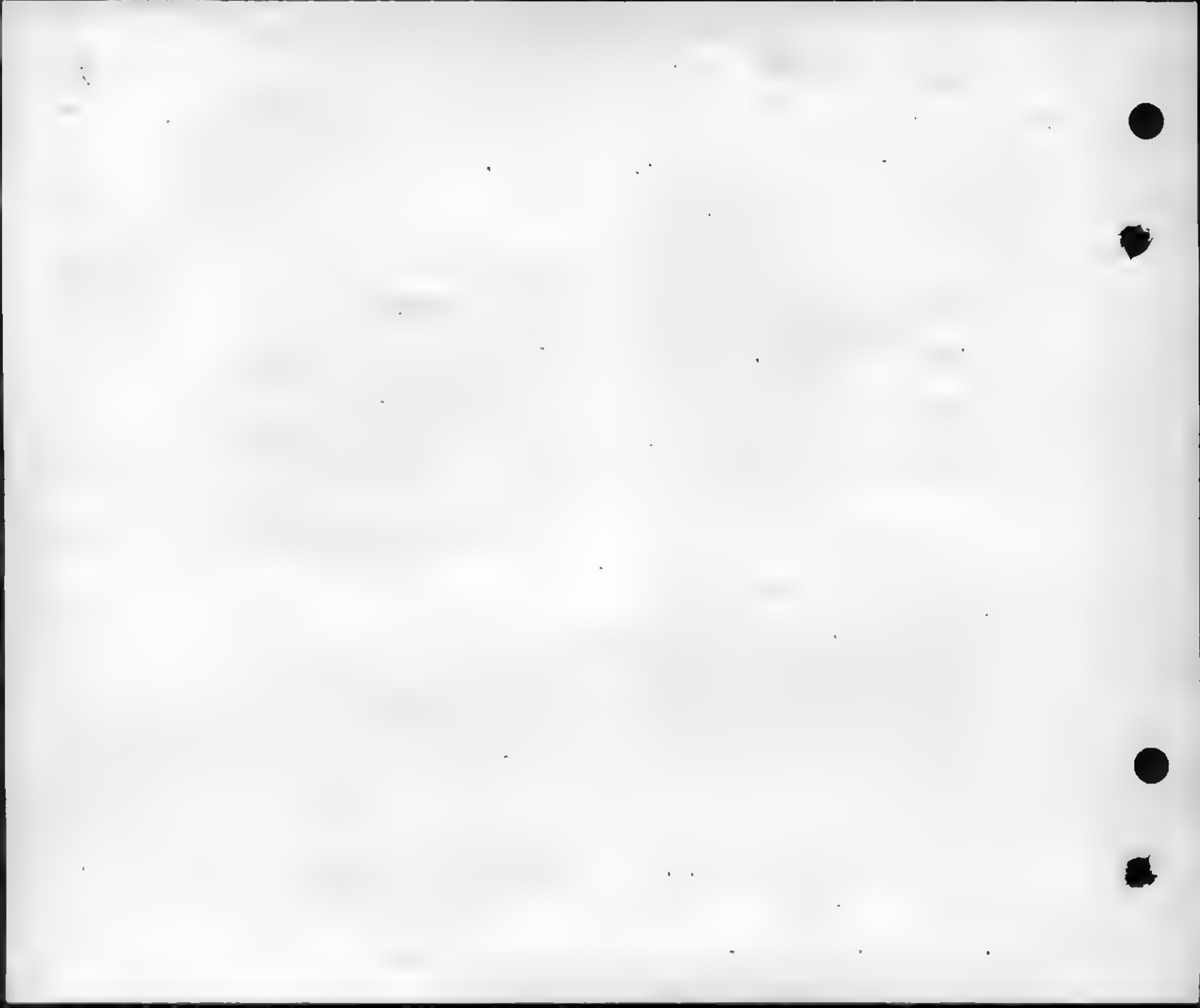
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2959

CERTIFICATE OF DEATH

02942

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Grace Last Stirling		4. DATE OF DEATH Month March Day 2 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1872	
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) BRAILLE OPER.		10b. KIND OF BUSINESS OR INDUSTRY Enoch Pratt Lib.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stirling		14. MOTHER'S MAIDEN NAME Elizabeth -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) -		16. SOCIAL SECURITY NO 218-09-9958	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 27, 19 61 , to March 2, 19 61 , that (I) (we) last saw the deceased alive on March 2, 19 61 , and that death occurred at 10P M, from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 3-3-61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, (Specify) BURIAL		23b. DATE THEREOF 3-6-61	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR 6 '61	
25b. REGISTRAR'S SIGNATURE William L. House			



TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2960

02943

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>				c. LENGTH OF STAY IN 1b <i>16 MO</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Long View Nursing Home</i>				e. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) First <i>SARANDA</i> Middle <i>K.</i> Last <i>THERIT</i>				4. DATE OF DEATH Month <i>March</i> Day <i>23</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JAN 7, 1877</i>	
9. AGE (In years last birthday) <i>84</i> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>PETER LEESE</i>				14. MOTHER'S MAIDEN NAME <i>Rebecca Yingling</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Mrs William Graf, Millers Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i>							
DUE TO (b) <i>Hypertensive Cardiovascular Disease</i>							
DUE TO (c) <i>Arteriosclerosis Generalized</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> <i>—</i> <i>—</i> <i>—</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>							
21. I certify that (I) (this hospital) attended the deceased from <i>March 22, 1961</i> to <i>March 23, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 23, 1961</i> and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Joseph E. Bush</i> M.D.				22b. DATE SIGNED <i>3/23/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>				22d. ADDRESS <i>HAMPSTEAD Maryland</i>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/26/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. David's German Lutheran</i>		23d. LOCATION (City, town, or county) (State) <i>Pa #2 York Co</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Bucker Haunert Pa</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 28 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR A CORONER: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by a hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2961
20946
CERTIFICATE OF DEATH

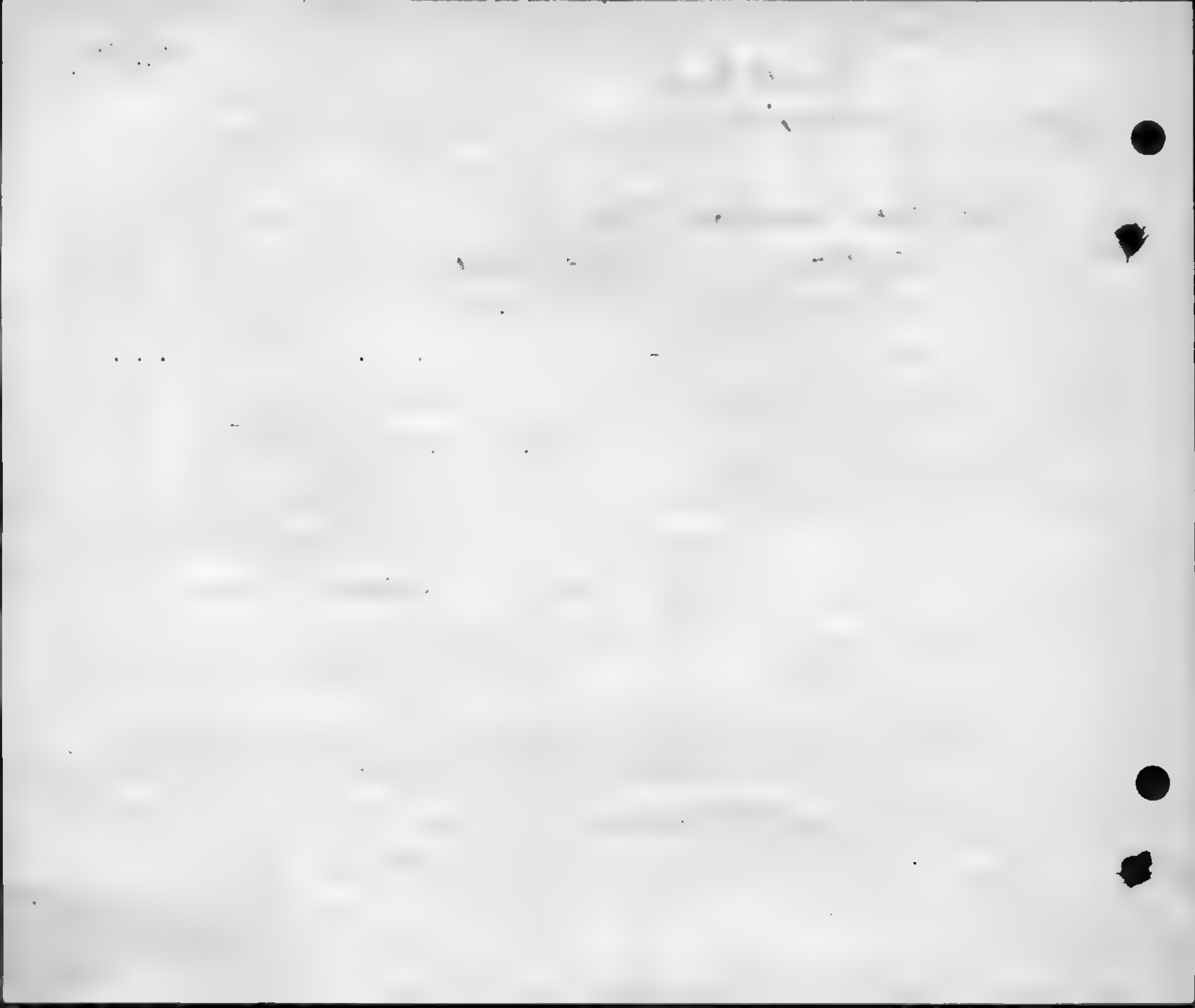
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle McClellan Last Vaughn		4. DATE OF DEATH Month March Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	
11. BIRTHPLACE (State or foreign country) Carroll Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Albert Vaughn		14. MOTHER'S MAIDEN NAME Laura Ellen Groff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Mrs. Russell Wantz, Jr. Taneytown, Md. R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Artery Occlusion 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic Heart Disease, Hypertension INTERVAL BETWEEN ONSET AND DEATH few weeks 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/30/59 , 19 to 3/31 , 1961, that (I) (we) last saw the deceased alive on 3/31 , 1961, and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. McVaugh		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Skiles C.O. Fuss & Son,		ADDRESS Taneytown, Maryland	
25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hance	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

2967
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02945

1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> <u>Westminster</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Westminster</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3101-4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jordan Convalescent Home</u>		f. N. <u>West</u> Avenue	
3. NAME OF DECEASED (Type or print) <u>ANNA</u>		4. DATE OF DEATH Last <u>March</u> 17, 19 <u>61</u>	
5. SEX <u>Female</u>	6. CO. OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1877</u>
9. AGE (in years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hess</u>		14. MOTHER'S MAIDEN NAME <u>Karolyn ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rev. Karl H. Wernheim - 1st, Church</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (Lobar) Left</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular Renal Disease</u> (a), stating the underlying cause last. (c) <u>Hypertension + Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u> </u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Severely</u> <u>yes</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 6, 1961</u> to <u>March 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1961</u> , and that death occurred at <u>8:40 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter Speicher</u> M.D.		22b. DATE SIGNED <u>3/18/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Walter Speicher</u>		22d. ADDRESS <u>Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Jackson, Son North & Anna Green</u>		24. ADDRESS <u>Balto 17, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2963

02946

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore #5			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 mos. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #5		d. STREET ADDRESS 941 N. Collington Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Holfus Last WEBER				4. DATE OF DEATH Month 3 Day 5 Year 19 61			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/76	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Holfus				14. MOTHER'S MAIDEN NAME Helena Schutze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis recurrent. DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease with DUE TO (c) auricular fibrillation.							INTERVAL BETWEEN ONSET AND DEATH hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-29-60 19____, to 3/5/61 19____, that (I) (we) last saw the deceased alive on 3/5/61 19____, and that death occurred at 8:45 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Agustín del Campo</i> M.D.				22b. ADDRESS Sykesville, Maryland		22c. PHYSICIAN'S NAME (Type) Agustín del Campo, M.D.	
22d. ADDRESS Sykesville, Maryland		22e. DATE SIGNED 3/5/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-61		23c. NAME OF CEMETERY OR CREMATORY Moneland Memorial		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank Cracherson ADDRESS 900 N. Chester St.				25a. REC'D BY REGISTRAR DATE MAR 7 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2964

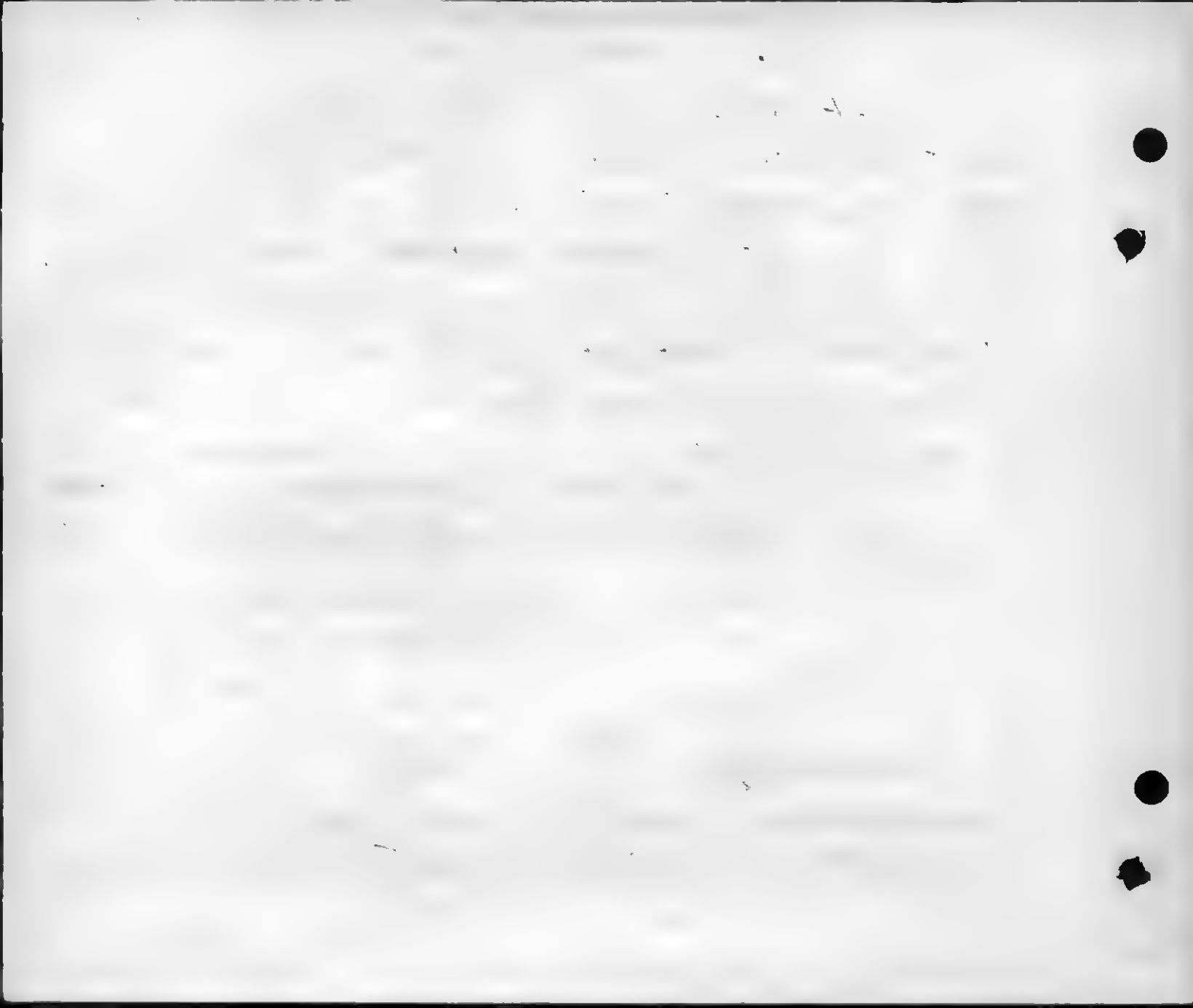
CERTIFICATE OF DEATH

Reg. Dist. No. 02947

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER X	
c. LENGTH OF STAY IN 1b 3 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GEN. DEL. CENTER ST. EXT.		d. STREET ADDRESS CENTER ST. EXT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUGUSTUS HENRY WEHRHAN		4. DATE OF DEATH Month Day Year MARCH 5 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13 1904
9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITORIAL		10b. KIND OF BUSINESS OR INDUSTRY ADV. CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME Henry Wehrhan		14. MOTHER'S MAIDEN NAME Bertha Wehrhan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-5276	
17. INFORMANT Wm. A. H. Wehrhan		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS DUE TO (c) 10 YEARS		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1959 to MARCH 11, 1961 , that I last saw the deceased alive on FEBRUARY 25, 1961 , and that death occurred at 10:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel I. Welliver M.D.		ADDRESS (Street, city or town, state) 19 RIDGE ROAD DATE SIGNED 3/5/61	
PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER		WESTMINSTER, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/18/61	22c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Garden	22d. LOCATION (City, town, or county) (State) Rural, Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James E. Thompson		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR MAR 8 '61		24b. REGISTRAR'S SIGNATURE Charles S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

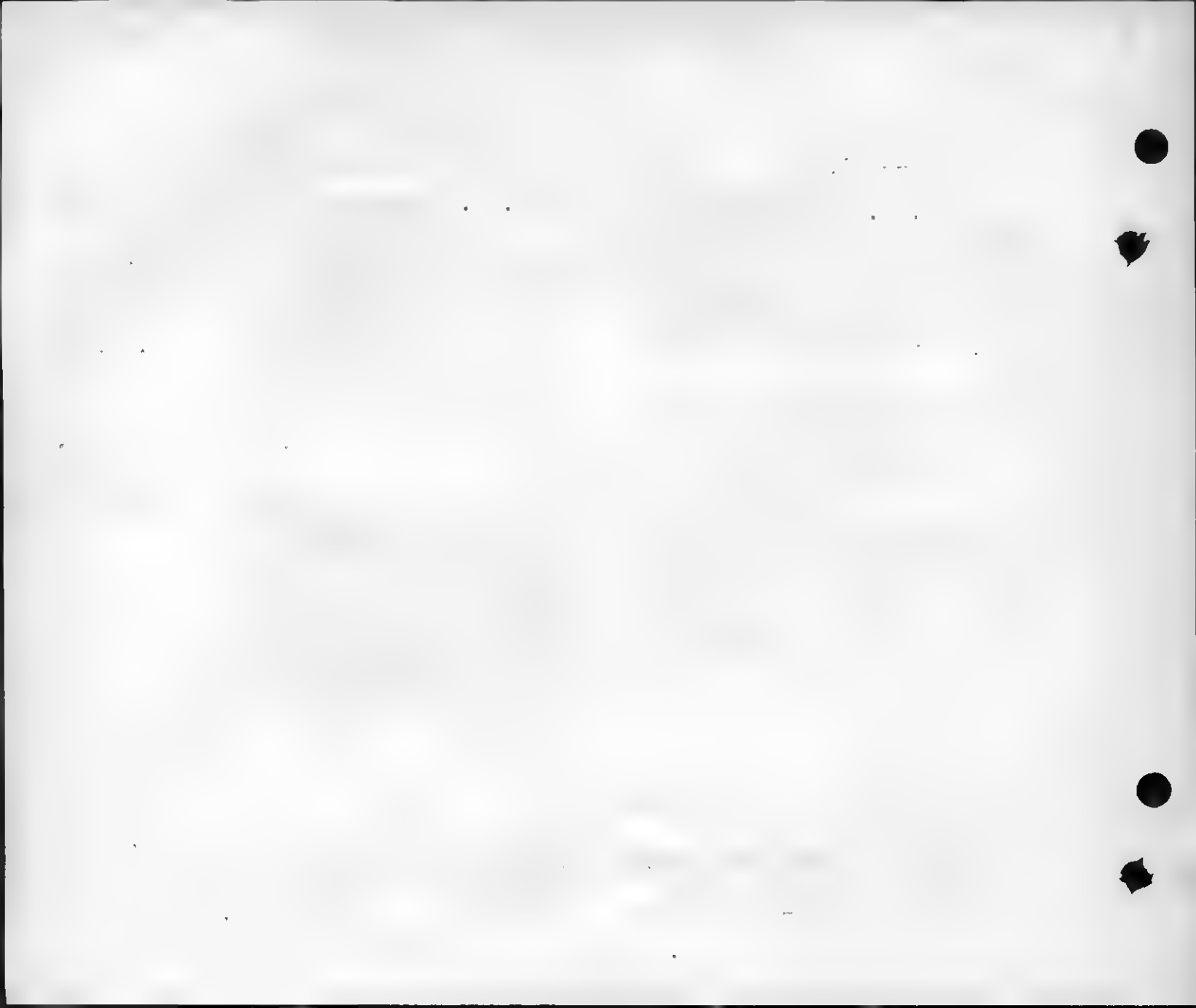
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2965

CERTIFICATE OF DEATH

02948

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural --- Gist				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--- Gist			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P. O. Sykesville				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First WILLIAM Middle WHALEN Last		4. DATE OF DEATH Month March Day 11 Year 1961					
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 6, 1868	9. AGE (In years last birthday) yrs. 92	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wesley Whalen				14. MOTHER'S MAIDEN NAME Louisa ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hollis Criswell, Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X Cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hours			
DUE TO (b) Arteriosclerosis							
DUE TO (c) Senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb 1957 to March 11, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 10:50 P.M. from the causes and on the date stated above							
22a. SIGNATURE W. Glenn Speicher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/13/61	
22c. PHYSICIAN'S NAME (Type) W. Glenn Speicher, M. D.				22d. ADDRESS Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-1961		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				25a. REC'D BY REGISTRAR DATE MAR 15 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



Arthur S. Kraus

VS. A15MB
5M 7/59



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02950

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIKESVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROUTE 140</u>		d. STREET ADDRESS <u>903 WINDSOR RD.</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HOWARD WILSON</u>	4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1961</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-44</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		9. AGE (in years last birthday) <u>16</u> yrs. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>61</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ARCHIE RONALDSON WILSON</u>		14. MOTHER'S MAIDEN NAME <u>BEATRICE JULIA HOLBROOK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO., 17. INFORMANT <u>ARCHE K. WILSON - 403 Windsor Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED SKULL</u> DUE TO (b) <u>TRAFFIC ACCIDENT</u> DUE TO (c) <u>TRAFFIC ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STRUCK BY AUTOMOBILE</u>	
20c. TIME OF INJURY Hour <u>8:15</u> p.m. Month <u>3</u> Day <u>10</u> Year <u>1961</u>	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ROUTE 140</u>	20f. (City or town) (County) (State) <u>WESTMINSTER CARROLL MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WEDD LAWN</u>		22d. LOCATION (City, town, or country) (State) <u>WEDD LAWN, MD.</u>	
23. FUNERAL DIRECTOR <u>Arthur H. Neuzel</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawiec</u>	
ADDRESS <u>903 Windsor Rd</u>		DATE <u>MAR 13 '61</u>	

DATE SIGNED

3/10/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

2968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02951

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 22days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Wohlers Last Wohlers		4. DATE OF DEATH Month March Day 2, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865
9. AGE (In years lost birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 95 Days 2 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Arteriosclerotic cardiovascular disease with atrial fibrillation and failure. DUE TO (c) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Two days. Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1960 to March 2, 1961 , that (I) (we) last saw the deceased alive on March 1, 1961 , and that death occurred at 3:50AM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 3/2/61	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 4 1961	
23c. NAME OF CEMETERY OR CREMATORY Lorraine		23d. LOCATION (City, town, or county) (State) Woodlawn Md	
24. FUNERAL DIRECTOR'S SIGNATURE Harry H. Annacore		25a. REC'D BY REGISTRAR APR 3 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Hume			

10482

CENTRAL IN DEPT

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by the funeral director, Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2965
CERTIFICATE OF DEATH

02952

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
c. LENGTH OF STAY IN 1b <u>9 years</u>				d. STREET ADDRESS <u>7 Willow Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7 Willow Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM FREDERICK YINGLING</u>				4. DATE OF DEATH <u>MARCH 20 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Yingling</u>				14. MOTHER'S MAIDEN NAME <u>Martina Groch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>214-34-3100</u>			
17. INFORMANT <u>Mrs. Wm. F. Yingling</u>				Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>decompensation + Hypertension + obesity + arteriosclerosis</u> DUE TO <u>—</u> DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>several years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1961</u> to <u>March 20, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 19, 1961</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Glenn Speicher</u>				22b. DATE SIGNED <u>3/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER</u>				22d. ADDRESS <u>Westminster Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Run Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr. Westminster, Md.</u>				25. REGISTERED BY REGISTRAR <u>—</u> DATE <u>MARCH 24 1961</u>			
				25b. REGISTRAR'S SIGNATURE <u>William S. Haug</u>			

MEDICAL CERTIFICATION

